LOYAL AMERICAN LIFE INSURANCE COMPANY®
PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604
Phone (800) 366-8354

INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM

The forms must be completed by the claimant. If the claimant is a minor, the primary insured parent must complete the forms. All questions on the forms must be answered in full. Incomplete or illegible answers may result in the delay of claim consideration. Please return the requested information as soon as possible for prompt processing.

The claimant is responsible for this information without expense to the Company.

- The enclosed **Statement of Claim** should be fully completed by the primary insured and the patient. Please make sure the Authorization at the bottom of the page is signed and dated.

- The **Physician's Statement of Claim** should be completed by your primary treating physician.

- Please provide a copy of the **Accident Report**, if one is available.

- Please provide an **Itemized Emergency Room Bill**.

- Please provide copies of itemized bills and/or treatment notes for any other related treatment, such as hospital, physician, physical therapist or ambulance bills.

- The enclosed **HIPAA** form, Authorization Form For Disclosures of a Claimant's Protected Health Information, should be fully completed by the **patient.**

- The enclosed **Personal Representative HIPAA** form, Authorization Form For Disclosures of a Claimant's Protected Health Information to Personal Representative, should be completed if someone other than the patient needs to be able to discuss sensitive policy or claim information with our office. The patient may also provide a copy of a current **General Durable Power of Attorney** in lieu of this form.

*******If you send receipts, please send **photocopies**. It is possible for a claim to be lost or damaged in the mail, and if the originals are sent you more than likely will not be able to get another copy.

This instruction form and our requests for additional information should not be considered a guarantee that payment will be made. Please make sure all documentation requested is fully completed and returned as soon as possible. If you have any questions, please contact our Customer Service Department.

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Statement of Claim - Accident Expense - Individual Policy

To be completed by the Insured (Complete all applicable sections)

Insured's name:	Phone: ( )	☐ Check here if your address has changed	Policy/Certificate No.
Insured's address:		Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced	
Insured's date of birth:	Social Security No.:	Employer's name & address:	
Claim is for: ☐ Self ☐ Spouse ☐ Child	Claimant's name (if not insured):	Sex of claimant: ☐ Male ☐ Female	Claimant's date of birth:
If dependent child is over age 19, indicate: ☐ Handicapped ☐ Student	If full time student, give name and address of school:	Claimant's occupation:	
How did the accident happen?	Where did it occur?	Date of accident:	Time of accident: Hour A.M. P.M
Employment related? ☐ Yes ☐ No			
Worker's Compensation claim filed? ☐ Yes ☐ No If yes: Date filed:_____ Claim #: _____			
Type of Treatment: ☐ Emergency Room ☐ Hospital – OutPatient ☐ Hospital – InPatient ☐ Doctors Office	List full name and address of all facilities where treated for this condition:		
List full name and address of all Physicians who have treated you for this condition.			

Warning: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

I further certify that I have read and understand the above Fraud Warning Statement and the additional Fraud Warning Statements that appear on the back of this page that might apply to me or my family.

Date:	Signature of CLAIMANT or Insured if Minor	Current Address

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ATTENDING PHYSICIAN'S STATEMENT OF CLAIM		
TO BE FULLY COMPLETED BY YOUR PRIMARY TREATING PHYSICIAN.		
PATIENT'S NAME (First, MI, Last)	PATIENT'S DATE OF BIRTH	INSURED'S NAME (First, mi, last)
INSURED'S SOCIAL SECURITY #	PATIENT'S SEX ☐ Male ☐ Female	INSURED'S ID or MEDICARE # (include any letters)
PATIENT'S ADDRESS (Street, city, state, zip)	INSURED'S POLICY #	
DATE FIRST CONSULTED FOR THIS CONDITION:	DATE LAST TREATED:	WAS PATIENT TREATED BY ANOTHER PHYSICAN(S), PRIOR TO YOUR TREATMENT ☐ YES ☐ NO
IF YES PROVIDE NAME AND ADDRESS OF PHYSICIAN'S KNOWN:		
DATE SYMPTOMS FIRST APPEARED	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS ☐ YES ☐ NO	
IF 'YES', PROVIDE DETAILS INCLUDING DATES OF TREATMENT AND DIAGNOSIS		
IF YOU REFERRED PATIENT TO ANOTHER PHYSICIAN, PLEASE PROVIDE NAME , ADDRESS OF PHYSICIAN, DATE OF REFERRAL:		
IS CONDITION DUE TO AN ACCIDENT? ☐ YES ☐ NO	IF YES, HOW DID ACCIDENT HAPPEN?	
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if not home or office)		
DID YOU ORDER HOSPITAL CONFINEMENT ☐ YES ☐ NO DATE ADMITTED: _____ DATE DISCHARGED: _____	FOR SERVICES RELATED TO HOSPITALIZATION, NAME & ADDRESS OF FACILITY	
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		
1.		
2.		
3.		
20. SIGNATURE OF PHYSICIAN OR SUPPLIER	21. YOUR SSN	22. PHYSICIAN'S/SUPPLIER'S NAME, ADDRESS, PHONE #
DATE	23. YOUR TAX ID #	

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AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. I authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to the Company's claims and underwriting representatives by and through the Company's contracted agent, LabOne.

2. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.

3. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 1604, Duncan, Oklahoma 73534-1604.

4. This authorization will expire twenty-four (24) months from the date the authorization is signed.

5. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitlement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment of benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization

6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.

7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.

8. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

If you are the representative of the claimant, describe the scope of your authority to act on the claimant's behalf:

_____

_____

Claimant Name_____

Name and relationship of claimant's Personal representative, if applicable

_____

Signature of claimant (or claimant's representative)

_____

Date of claimant's (or claimant's representative) signature_____

A signed copy of this form will be provided any time upon request.

AUTHORIZATION FORM FOR DISCLOSURES OF AN INSURED'S PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONAL REPRESENTATIVE(S)

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I hereby authorize the use or disclosure of protected health information about me by Loyal American Life Insurance Company (hereinafter "the Company") as described below.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

Name	Address	Relationship	Date of Birth	Social Security #

Describe fully the protected health information that is NOT allowed to be disclosed to the above named personal representative(s).

_____

_____

I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the Notice of Privacy Practices of the Company, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Officer at P.O. Box 1604, Duncan, Oklahoma, 73534-1604.

This authorization will expire upon the earliest of the following:
This date: _____; or twenty-four (24) months from the date the authorization is signed.

I understand that I am not required to sign this authorization form and that the Company will not condition the provision of payment to me on the signing of this authorization. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

_____ _____
Insured Name Personal Representative (if applicable)

_____ _____
Signature of Insured or Representative Relationship of Representative to Insured

_____ _____
Date of Signature Insured's Policy Number