FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147, (440) 922-5151

ACCIDENTAL INJURY and ICU CLAIM FORM

Instructions: 1. Have the claimant answer all questions, sign and date SIDE 1.
2. Have the treating physician complete SIDE 2.

If filing an **accidental injury claim** submit one claim form for each accident along with copies of all itemized hospital and medical bills that apply, x-ray reports diagnosing any fracture(s) and police report, if applicable.

If filing an **accidental death claim** submit one claim form completed by the Spouse/Executor and the Physician along with an original, certified copy of the Claimant's death certificate, police report and autopsy report, if applicable.

If filing an **intensive care claim** submit one claim form for each hospital admission along with a copy of the itemized hospital bill listing the intensive care charges and an ambulance bill, if applicable.

1. Policyowner's Name: _____ 2. Policy #: _____

Claimant's Information:

3. Name: _____ 4. Social Security No.: _____

5. Address: _____ 6. Phone number: (_____) _____

_____ 7. Date of birth: _____

8. Occupation: _____

9. Relationship to Policyowner: ❑ Self ❑ Spouse ❑ Son ❑ Daughter ❑ Other _____

10. Date of illness/accident: _____ 11. Date first consulted physician: _____

12. Place of illness/injury: _____

13. Describe how illness/injury occurred: _____

_____

14. Nature of illness/injury: _____

_____

15. List all treating physicians. Include name and phone number: _____

_____

16. If hospitalized, when? From _____ to _____ Hospital phone: (_____) _____

17. Hospital name: _____
City State

IMPORTANT NOTICE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION MUST BE SIGNED BEFORE CLAIM CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, pharmacy benefit manager or prescription data base, including prescription drug records, insurance company, or MIB, Inc. to furnish to Family Heritage Life Insurance Company of America or its representative or permit said insurance company or its representative to review for the purpose of evaluating claims for benefits any information with respect to any illness or accident, medical history or medical records. I understand that a photostatic copy of this authorization shall be considered as valid as the original and shall remain valid 30 months from the date signed. I further understand that I or my authorized representative may request a copy of this authorization.

Signed _____ Date _____
Patient, Parent (If Child) or Executor

If the Claimant is unable to provide a signature, please include a copy of a power of attorney, letter of executor and or a death certificate

Patient's Name: _____ Policy #: _____

SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

Physician's name: _____ Phone number: ( ) _____

Specialty: _____

Address: _____

Accident Claims:

1. Diagnosis: _____ 2. Diagnosis code(s): _____
3. Was this condition due to an accidental injury? ❑ Yes ❑ No 4. Date accident occurred: _____
5. Nature of the injury: _____
6. Where did the injury happen? _____
7. Date patient first consulted you for this condition: _____ Date of most recent exam: _____
8. Has the patient ever had the same or similar condition? ❑ Yes ❑ No If Yes, when? _____
9. Describe any other disease or infirmity affecting the present condition: _____
10. Referring physician's name, address and phone number: _____
11. Was the patient under the influence of any intoxicant or narcotic at the time of the accident? ❑ Yes ❑ No
    If Yes, was it taken under the direction of a physician? ❑ Yes ❑ No If Yes, please explain: _____
    Did it contribute to the injury? ❑ Yes ❑ No If Yes, please explain: _____
12. Was the patient hospitalized solely due to this condition? ❑ Yes ❑ No
    If hospitalized, name and address of the facility: _____
    Date admitted: _____ Date discharged: _____
13. List any applicable CPT procedure codes: A) _____ B) _____ C) _____
14. Do you have records on the patient's past medical history? ❑ Yes ❑ No

Intensive Care Claims:

1. Has the patient **ever** been diagnosed with or treated for a heart attack, heart disease or stroke? ❑ YES ❑ NO
2. Date of first diagnosis: _____ 3. Date of first treatment: _____
4. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO
   If YES, when? _____
5. List any specific dates of Intensive Care Unit confinement: _____
6. Has the patient ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ YES ❑ NO If YES, when? _____

_____ _____
Completed by (please print) Position

_____ _____
Physician's Signature Date