Bankers Fidelity®

CLAIM FORM

Mail To: **Bankers Fidelity Life Insurance Company®**
P. 0. Box 105652, Atlanta, Georgia 30348-5652

Toll Free Claim Number: 1-866-458-7499, 8:00 A.M. to 5:30 P.M. (EST)
www.bankersfidelity.com

Has a Claim been filed before for this loss? ❒ Yes ❒ No

Policyholder Name *(First, Middle & Last)*		Policy Number	Date of Birth
Street Address ❒ *Check here if new address*		Home Phone Number ( )	Work Phone Number & Ext. ( )
(City, State & Zip Code)		Social Security Number	Male ❒ Female ❒
Patient *(First, Middle & Last)*	Age	Patient's Social Security Number	Date of Birth

Patient is your: ❒ Self ❒ Spouse ❒ Dependent Child If patient is your child, is he/she full-time student? ❒ Yes ❒ No

This Claim is for: ❒ Accident ❒ Disability ❒ Critical Illness ❒ Wellness ❒ Hospital Indemnity
❒ Cancer (If claim is being filed for cancer, enclose pathology report) ❒ Other

What illness or injury are you claiming? _____

Date first sought treatment for this illness or injury _____

Dates confined to your home_____to_____ Dates unable to work_____to_____

Have you returned to your main duties? ❒ Yes ❒ No

Date returned part-time_____ Date returned full-time_____

List all doctors who have treated you for this condition:

Name	Address	Phone Number

Have you received treatment, medication or advice from a doctor in the past for this or a similar condition? ❒ Yes ❒ No

If "Yes," provide the date, name and address of physician:

Date	Name	Address

If you were hospitalized, Please provide Date admitted_____ Date Discharged _____

Hospital Name and Address _____

ACCIDENTAL INJURY: (Attach copy of police report if auto accident.)

Date of accident _____ Time of accident _____❒ A.M. ❒ P.M.

On the job? ❒ Yes ❒ No If "No", where did it happen?_____

Authorization To Release Information

I hereby authorize any physicians, practitioners, hospitals, clinics, pharmacists, insurance companies, employers, credit reporting agencies, government agencies and other persons or institutions to furnish Bankers Fidelity Life Insurance Company® or its authorized representative copies of any and all information, data or records you have regarding any illness or injury, physical or mental condition, medical history, consultation, prescriptions, treatment, or employment pertaining to me. I understand that I have a right to request a copy of this authorization. A photocopy of this authorization shall be considered effective and valid as the original.

Dated: _____ Signed:X _____

Please read notices on the reverse of this form

If you are claiming disability benefits, the Employer's Statement and Attending Physician's Statement must be completed by the appropriate parties.

NOTICE

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Alabama Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

District of Columbia Residents Only
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents Only
WARNING: Any person who knowingly and with intent to injury, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland Residents Only
WARNING: Any person who, with intent to defraud or knowing that he 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 as determined by a court of competent jurisdiction.

Pennsylvania Residents Only
WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Residents Only
WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Residents Only
WARNING: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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EMPLOYER'S STATEMENT

Mail To: **Bankers Fidelity Life Insurance Company®**
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TO BE COMPLETED BY EMPLOYER

Employee's Full Name		Date of Birth	
Employee's Home Address		State	Zip
Employer	Address	State	Zip
Job Title		Employee's Date of Hire	

Last active date employee worked _____

Reason for stopping work

❒ Injury ❒ Vacation ❒ Retired ❒ Terminated

❒ Sickness ❒ Leave of Absence ❒ Resigned ❒ Other _____

• If "Yes" checked for retired, terminated or resigned please give date: _____

Is disability work related? ❒ Yes ❒ No

Has the employee filed for Worker's compensation? ❒ Yes (attach copy of first report of Injury) ❒ No

Total Disability: What dates did employee give up ***all*** duties? From _____ to _____

Partial Disability: What dates did employee perform only ***Partial*** duties? From _____ to _____

Does the employee's job have lifting requirements? Min lbs. _____ Max lbs. _____

Percentage of: Sitting _____% Standing _____% Walking _____%

Date employee returned to work _____

Employer Name		
Employer Mailing Address	State	Zip
Printed name and title of representative completing this form	Phone Number	
Signature of representative completing this form	Date	

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Address / City / State / Zip Code	Date of Birth

1. Diagnosis and origin of injury _____

_____

ICD-10 code _____

Confirmed by X-Ray? ❒ Yes ❒ No

2. When did symptoms first appear or accident happen? Date *(Month, Day & Year)* _____

3. When did patient first consult you for this condition? Date *(Month, Day & Year)* _____

4. How did conditions originate? _____

_____

_____

5. Has patient ever had same or similar condition? ❒ Yes ❒ No

(If "Yes," state when and describe) _____

_____

_____

6. Describe any other disease or infirmity affecting present condition. _____

_____

7. Nature of Surgical or Obstetrical procedure, if any.

Dates _____ ❒ Closed Reduction ❒ Open Reduction ❒ Metal Fixation

Description _____ Procedure Code _____

8. Give dates of treatment, and nature of treatment other than surgical: _____

❒ Office ❒ Home ❒ Hospital

9. Is patient still under your care for this condition? ❒ Yes ❒ No If discharged, give date _____

10. If patient was hospitalized, give: Dates of Confinement: From _____ To _____

Name and address of hospital _____

_____

11. How long was or will patient be continuously **totally** disabled (unable to work)? From _____ To _____

12. Is **total** disability expected to be permanent? ❒ Yes ❒ No Expected date to return to work _____

13. How long was or will patient be **partially** disabled? From _____ To _____

14. Please list name and address of referring physician or any other physician who treated patient for this sickness or injury.

Name _____ Address _____

Name _____ Address _____

_____ _____ _____

Physician's Name (Print) Degree Tax Identification Number

_____ _____

Physician's Signature Date

_____

Physician's Address (Street, City/Town, State or Province & Zip Code) Telephone Number