APL Claims Department
P.O. Box 925
Jackson, MS 39205-0925

Phone: 800-256-8606
Fax: 877-365-9423
Web: www.ampublic.com

Accident and Health

CLAIMANT'S STATEMENT

Name of Claimant	SS #	Policy/Certificate #
Street Address or P.O. Box	City, State and Zip	
Date of Birth	Relationship to Primary Insured	Telephone #
Name of Primary Insured	SS #	Primary Insured's Employer
Is this claim due to an accident?	Date Accident Occurred:	Will a Worker's Comp claim be filed?
Describe Illness/Injury. If injury, how did it occur?		
IMPORTANT: SUBMIT A COPY OF THE POLICE REPORT IF CLAIM IS DUE TO A VEHICLE ACCIDENT. SUBMIT A COPY OF THE PATHOLOGY REPORT IF CLAIM IS DUE TO CANCER.		
Were you hospitalized? Where?	Dates of hospitalization From / / to / /	
Have you ever had symptoms of this condition before? When?		
Names and addresses of Attending Physicians (if necessary, list on separate piece of paper and attach):		
Name _____	Name _____	
Address _____	Address _____	
FOR DISABILITY CLAIMS ONLY Date you stopped working due to disability _____ List job duties:	Date you returned or will return to work _____ Average Monthly Earnings _____	

WARNING - AL - 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. **AK -** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **AZ -** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. **AR, DC, LA, RI and WV -** 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. **CA and TX -** For your protection California and Texas law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **CO -** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **DE, ID and OK -** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **FL -** Any person who knowingly and with intent to injure, 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. **IN -** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **KY -** Any person who knowingly and with intent to defraud any insurance company or other person files a 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. **ME, TN, VA and WA -** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MD -** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **MN -** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **NH -** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. **NJ -** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **NM -** 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 CIVIL FINES AND CRIMINAL PENALTIES. **OH -** 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 is guilty of insurance fraud. **PA -** 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.

BY SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Primary Insured's Signature	**Claimant's Signature**	**Date Signed**

EMPLOYER'S STATEMENT: FOR DISABILITY OR WAIVER OF PREMIUM CLAIMS ONLY

1. Date of first absence due to disability	2. Date employee returned to work	
3. Date hired	4. Date of termination if terminated	
5. Date of retirement if retired	6. Did employee take disability retirement?	
7. REQUIRED: If the employee pays the premium for this plan through payroll deduction, is the premium sheltered under a Section 125 (cafeteria) plan? _____ Is the premium paid by the employer as an employee benefit? _____		
8. Has claim or will claim be made for Worker's Compensation Benefits? _____If yes, what is the status of the claim?		
9. Will you provide "light duty" if employee is released with restrictions?		
10. Employer Name	11. Employer Telephone #	
Authorized Signature	**Title or Position**	**Date**

ATTENDING PHYSICIAN'S STATEMENT: For routine FIRST-AID claims, this side is not usually required if a copy of the bill showing Patient's name, diagnosis, charges and date incurred is furnished along with Claimant's Statement on reverse side.

1. Diagnosis and concurrent conditions. **ICD CODES REQUIRED:**		
2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No	3. If condition is due to an accident, give details of the accident:	
4. Is condition due to pregnancy? ☐ Yes ☐ No If yes, expected delivery date: _____ Date of LMP _____		
5. Report of Services (or attach itemized bill): Date of Service CPT Code Description of Medical Service Rendered Charge _____ _____ _____ $ _____ _____ _____ _____ $ _____ _____ _____ _____ $ _____ _____ _____ _____ $ _____		
6. Date symptoms first appeared or accident happened	7. Date patient first consulted you for this condition	
8. Has patient ever had same or similar condition? ☐ Yes ☐ No If "yes", when and describe:	9. Patient still under your care for this condition? ☐ Yes ☐ No Date last seen: _____	
10. Patient was continuously and totally disabled (unable to perform substantially all of his/her occupational duties) From_____Through _____	11. Patient was partially disabled (able to perform some but not all of his/her occupational duties) From_____Through_____	
12. If still disabled, date patient should be able to return to work?	13. Patient was hospital confined From_____Through _____	
14. Does patient have other health coverage? If "Yes", please identify:	15. Was patient referred to you by another physician"? ☐ Yes ☐ No If "Yes", please provide name of referring physician:	
Physician's Name (Please Print)	Degree	IRS Identification Number
Address	Phone Number	
Physician's Signature	**Date**	

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record and history of treatment for physical and/or emotional illness (to include psychological testing, except psychotherapy notes) to individuals representing American Public Life Insurance Company (APL) who are involved in determining whether I am eligible for benefits under my insurance coverage. Specified entities include: licensed physicians or medical practitioners; hospitals, clinics, or medically-related facilities; health plans; Veteran's Administration or other government healthcare payors or providers; past or present employers; pharmacies; insurance companies; the Social Security Administration; retirement systems; Departments of Motor Vehicles; and Workers' Compensation Carriers.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or delay of benefits. I understand that I may revoke this authorization at any time by writing to APL, P.O. Box 925, Jackson, MS 39205-0925 or by calling 1-800-256-8606. I understand that my right to revoke this authorization may be limited to the extent that: APL has taken action in reliance on this authorization; or, the law provides APL with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization is as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

This authorization will expire twenty-four months from the date it is signed or upon termination of my insurance coverage with APL, whichever occurs first.

Signature (Patient) or Personal Representative (if applicable) Printed Name (Patient)

Date of Birth Date Signed

I certify this information is true and correct.

Relationship of Personal Representative to Patient

_____

If authorization is supplied by a personal representative, evidence of the authority to act on behalf of the insured must be included.

Please retain a copy of this authorization for your personal records, or you may request a copy by contacting our company. **Certain products administered by American Public Life Insurance Company are underwritten by American Fidelity Assurance Company.**