



Accident Claim Statement

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:

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.

If you live in the states of Arizona or New Jersey, the following statement applies to you:

A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island, the following statement applies to you:

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.

If you live in the state California, the following statement applies to you:

Any person who knowingly presents a 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.

If you live in Colorado, the following statement applies to you:

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you:

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

If you live in the District of Columbia, Tennessee, or Virginia, the following statement applies to you:

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.

If you live in New Hampshire, the following statement applies to you:

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.

Assurant Employee Benefits is the brand name for insurance products underwritten and issued by Union Security Insurance Company. In this document, the terms "we," "us," "our," and the like, refer to each as applicable.

If you live in New York the following statement applies to you:

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 act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If you live in Minnesota, the following statement applies to you:

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:

Any person who knowingly presents a 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.

If you live in a state other than mentioned above, the following statement applies to you:

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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

If filing a claim for Wellness Benefits you may use the Employee Paid Supplemental Claim Form KC4700A, if applicable to your policy, or complete section 1 and 5 (and 2 or 3 if applicable).

Insured Employee Instructions for filing an Accident Claim

1. Complete Parts 1 and 4.
2. Complete Part 2 or Part 3 if filing for a dependent.
3. Have the physician complete Part 6.
4. Sign and date the Authorization Sections.
5. Provide Documentation:

Attach an itemized bill or the medical records for each claim to be considered. Some documentation can be obtained by requesting a copy of the hospital bill (UB04) or HCFA1500 (non-hospital bill) from your healthcare provider. The medical documentation needs to include the date of service, the type of service and the name of the provider of the service.

Please include the following documents for all that apply:

Hospitalization: copy of hospital bill indicating diagnosis, services or treatment, and days hospitalized

Surgery: a copy of the operative report

Motor Vehicle Accident or any incident investigated by a law enforcement agency: a copy of the police report

Death: a certified copy of the death certificate for the deceased

Other: Copy of medical bills, physician records, ambulance charges, lodging and transportation expenses, and other appropriate documentation to support claim for benefits

**HIPAA Authorization For Release
of Protected Health Information**



Insured/Member name _____ SSN _____ DOB _____

Claimant name _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, insurance or reinsurance company or their authorized representatives, pharmacy, pharmacy benefits manager, or any pharmacy-related service entity, Social Security Administration, governmental agency, consumer reporting agency, vocational provider or employer having medical information, with respect to any physical or mental condition of mine, or non-medical information about me.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company, and their authorized representatives ("Companies").

I hereby authorize the use or disclosure of my protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies to determine my eligibility for benefits and to process my claim. Such information may include, but not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes (excluding psychotherapy notes), pharmacy records, strength/functional testing, records regarding my Social Security FICA earnings history, Worker's Compensation, State Disability, credit, and earnings and employment history.

The sole purpose of this disclosure is for the adjudication of my claim for insurance benefits under the above-referenced Policy.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only - we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be disclosed to or used by the insured member under the above policy.
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until my claim ends.

SIGNATURE OF CLAIMANT OR LEGAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL CLAIMANT REPRESENTATIVE

RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please mail or fax your Authorization to the address listed below:

Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568 • F 816.474.2320

Accident Claim Statement



Part 1 – To be completed by Insured Employee (Please print or type.)

Full name (As it appears on your Social Security card.)		Policy number	
Employer name		Employer phone number	
This claim is being filed for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow			
Date of birth	Social Security number		Home phone number
Street address		City	State Zip
Mobile phone number		E-mail address	
Did injury result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed			

Part 2 – To be completed by spouse if benefits are for spouse (Please print or type.)

Full name (As it appears on your Social Security card.)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth	Social Security number		Mobile phone number
Did injury result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed			

Part 3 – Complete for dependent if benefits are for dependent (Please print or type.)

Full name (As it appears on your Social Security card.)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth	Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security number	Mobile phone number
If over age 19, but less than 25, full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," attach copy of recent semester grade report.			
Name of school		School administration phone	
Street address		City	State Zip
Did injury result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed			

If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority and sign below.

Signature _____ Relationship to claimant _____

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Claimant's signature _____ Date _____

Part 4 – Claim Information *(Please print or type. If necessary, attach separate sheet.)*

Date of accident	Time of accident
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Description of accident

Primary physician name	Phone
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Primary physician address

Hospital name	Phone
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Hospital address

In order for benefits to be processed, please provide documentation of services provided or performed related to the accident. The itemized documentation must include the name of the provider, date of service, type of service and charge.

The following checklist can assist in your submission. *(Check all that apply.)*

- | | |
|---|--|
| <input type="checkbox"/> Treatment in the emergency room | <input type="checkbox"/> Appliance (wheelchair, brace, crutches, walker) |
| <input type="checkbox"/> Accident follow-up care | <input type="checkbox"/> Blood/Plasma/Platelets |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Lodging |
| <input type="checkbox"/> Intensive Care Unit (ICU) | <input type="checkbox"/> Major diagnostic exam |
| <input type="checkbox"/> Specified injuries: burns, dislocations, coma, paralysis, fractures, lacerations, etc. | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Specified surgical procedures | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Accidental death | <input type="checkbox"/> Rehabilitation unit |
| <input type="checkbox"/> Accidental dismemberment | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Disability benefit (spouse) |

Part 5 – Wellness Screening Benefit - If applicable to your policy.

This claim is being submitted for

(Attach supporting documentation/provider name and date of service.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Cardiac exercise stress test | <input type="checkbox"/> CEA (blood test for colon cancer) | <input type="checkbox"/> Serum protein electrophoresis |
| <input type="checkbox"/> Fasting blood glucose test | <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Carotid doppler |
| <input type="checkbox"/> Blood test for lipids, including total cholesterol, LDL, HDL and triglycerides | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Electrocardiogram |
| <input type="checkbox"/> Breast ultrasound or mammography | <input type="checkbox"/> Flexible sigmoidoscopy | <input type="checkbox"/> Echocardiogram |
| <input type="checkbox"/> CA15-3 (blood test for breast cancer) | <input type="checkbox"/> Hemocult stool analysis | |
| <input type="checkbox"/> CA125 (blood test for ovarian) | <input type="checkbox"/> Pap smear | |
| | <input type="checkbox"/> PSA (blood test for prostate cancer) | |

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

Part 6 – Physician’s Statement - *This statement must be filled in completely by a physician. (Please print or type.)*

Was injury the result of any of the following?

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Attempted suicide | <input type="checkbox"/> Intoxication | <input type="checkbox"/> Use of drugs |
| <input type="checkbox"/> Committing a felony | <input type="checkbox"/> Self-inflicted | <input type="checkbox"/> Work-related |
| <input type="checkbox"/> Complication of treatment | | |

Date of accident	Diagnosis	Date of diagnosis	ICD-9 code
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Has this patient been treated for this same or similar condition prior to this occurrence? Yes No

If “Yes,” please provide diagnosis, the dates of treatment and names of other medical providers.

Provide the name, address and phone number of any referring physicians.

For services related to a hospitalization, please provide the following. *(Please print or type.)*

Name of hospital				
Street address of hospital	City	State	Zip	Phone
Admission date	Discharge date			

Are you the parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the patient? Yes No

Physician’s Information *(Please print or type.)*

Name	Degree	Specialty/Board Certification		
Street address	City	State	Zip	
Phone	Fax	Physician’s EIN or SSN		
Physician’s signature	Date			

DO NOT PRE-DATE