USAble Life
Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone: (501) 378-5856 (800) 370-5856

Accident Benefits
Claim Form & Instruction Packet

Dear Policyholder:

Thank you for choosing USAble Life to provide your accident coverage. We have included these instructions and the necessary forms to assist you in the event you need to file a claim. Please remember that claims must be received within 90 days of the loss or date of service. You and your attending physician must complete the claim forms for Medical Expenses, Disability and Accidental Death. Disability claims also require your employer's statement. An Authorization for Release of Medical Records must be completed and returned along with the completed claim form. If faxing a claim, the original must also be mailed.

IMPORTANT NOTE: Losses resulting from motor vehicle accidents or homicide require a copy of the investigating officer's report. Incomplete claims cannot be processed and will be returned to you.

CLAIMS FOR MEDICAL EXPENSES

1. Complete the Insured's Statement on the back of this page.
2. Obtain the Attending Physician's Statement - Medical Expenses found in this packet.
3. Obtain ITEMIZED bills from all medical providers.
4. Complete the Authorization for Release of Medical Records.
5. Mail the completed forms and bills to USAble Life.

DISABILITY (Accident/Sickness Disability Rider - Principal Insured Only)

1. Complete the Insured's Statement on the back of this page.
2. Obtain the Attending Physician's Statement - Disability Rider found in this packet.
3. Obtain the Employer's Statement.
4. Complete the Authorization for Release of Medical Records.
5. Mail the completed forms to USAble Life.

ACCIDENTAL DEATH

1. Complete the Insured's Statement on the back of this page.
2. Obtain the Attending Physician's Statement - Accidental Death found in this packet.
3. Obtain a CERTIFIED DEATH CERTIFICATE (available from funeral home).
4. Complete the Authorization for Release of Medical Records.
5. Mail the completed forms and death certificate to USAble Life.

WELLNESS BENEFIT (if applicable to your policy)

1. Please mail us an ITEMIZED bill for the covered test or service. Payment will be mailed to the address on the bill. Please make sure this address is correct. (Do not rely on your physician or hospital to file your claim.)
2. You do NOT need a claim form or an Authorization for Release of Medical Records to collect reimbursement for these benefits BUT the following information must be submitted:
   * Insured's Name and Social Security Number
   * Policy Number (very important)
   * Patient's Name, Date of Birth, and Social Security Number
   * Date of Service
   * You may write the above on the itemized bill for submission

Mail Claim Forms & Bills to:
USAble Life
ATTENTION: CLAIMS DEPARTMENT
PO Box 1650, Little Rock, AR 72203-1650
1-800-648-0271 or (501) 375-7200

For Questions or Assistance Call:
USAble Life
1-800-370-5856 or (501) 378-5856
8:00 a.m. - 4:30 p.m. Central Time

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone: (501) 378-5856 (800) 370-5856

Accident Benefits Statement of Claim

INSURED'S STATEMENT

Name of Insured	Social Security #	Age	Sex ☐ Male ☐ Female
Home Address (Number and Street) (City, State) (Zip)			Daytime Telephone ( )
Name of Person Suffering Loss	Date of Birth	Sex ☐ Male ☐ Female	Relation to Insured
Home Address (Number and Street) (City, State) (Zip)			
Loss Suffered			
Name of Claimant	Social Security #		Date of Birth
Relation to Insured			Claimant is ☐ Beneficiary ☐ Insured ☐ Other
Home Address (Number and Street) (City, State) (Zip)			Daytime Telephone ( )
Where Injury Happened (Street, City, State)	When Injury Happened (Date and Time)		Date of Death (if applicable)
How Injury Happened			

Names and addresses of all physicians who attended or prescribed for the insured in the past 5 years

Physician	Address	Dates of Attendance	Disease or Condition

Names and addresses of all hospitals where insured was treated within 5 years preceding accident.

Hospital	City/State	Dates of Treatment	Disease or Condition

I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (or its representatives) and to permit them to examine and copy such information. I understand that USAble Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the company.

A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

Date:_____ **Signature of Claimant:**_____

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CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign this form.
2. To obtain the Attending Physician's Statement(s).
3. To obtain a copy of the investigating officer's report if loss due to motor vehicle accident or homicide.
4. To obtain the Employer's Statement (Disability Riders and Principal Insured Only).
5. To attach ITEMIZED bills.
6. To complete the Authorization for Release of Medical Records.

ATTENDING PHYSICIAN'S STATEMENT - MEDICAL EXPENSES

Please Answer All Applicable Questions.

Name of Patient	Date of Birth

Nature of Injury (Include ICD Codes)	When Did it Occur?

Date Patient First Consulted You	Has Patient Ever Had Same or Similar Condition? ☐ No ☐ Yes If Yes- When: _____

If loss of limb, was it through or above wrist or ankle joint? ☐ Yes ☐ No

If loss of sight, is it permanent or irrecoverable? ☐ Yes ☐ No If Yes, on what date did it become so? Date:_____

If No, what percentage of sight remains?

Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? ☐ Yes ☐ No

If No, Please Explain:

Were any surgical procedures involved? ☐ Yes ☐ No Please Describe:	Date Performed

If loss due to burn, specify degree and size:

☐ First Degree
☐ Second Degree _____ Percentage of Body Surface Burned
☐ Third Degree _____ Square Inches of Body Surface Burned

If loss due to dislocation, complete separation? ☐ Yes ☐ No Open Reduction ☐ Closed Reduction ☐

If loss due to fracture:

☐ Simple ☐ Open Reduction
☐ Compound ☐ Closed Reduction

If loss due to laceration:

Total Length
☐ Less than 5.08 cm.
☐ 5.08 - 15.24 cm.
☐ Greater than 15.24 cm.

Type of repair
☐ Stitches ☐ Glue
☐ Staples ☐ Other

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician's Signature	**Date**

Physician's Name	**Degree**

Address	**Telephone ( )**	**Fax ( )**

City	**State**	**Zip**

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CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign Insured's Statement.
2. To attach ITEMIZED bills from all medical providers.
3. To Complete the Authorization for release of Medical Records.

RETURN TO:
USAble Life
P.O. Box 1650*
Little Rock, AR 72203

ATTENDING PHYSICIAN'S STATEMENT - DISABILITY RIDER

Name of Patient | Date of Birth

HISTORY

(a) When did symptoms first appear or accident happen?

(b) Date patient ceased work because of disability

(c) Has patient ever had same or similar condition? ☐ Yes If "Yes" state when and describe ☐ No

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(e) Name and address of other treating physicians

DIAGNOSIS

(a) Diagnosis (including complications) and ICD-9 Code

(b) If pregnancy, (E.D.C.)

(c) Objective findings (including current x-rays, EKG's laboratory data and any clinical findings)

TREATMENT

(a) Date of first visit

(b) Date of last visit

(c) Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (Specify)

(d) Nature of treatment (including surgery and medications prescribed, if any)

PROGRESS

(a) Is patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No
If yes, give Name and Address of Hospital _____ Confined from _____ through _____

PROGNOSIS

(a) Is patient now totally disabled?
Patient's Job ☐ Yes ☐ No
Any Other Work ☐ Yes ☐ No

(b) When do you expect a fundamental or marked change in the future? ☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ Never Applies To: ☐ Patient's job ☐ Other Work

REHAB

(a) Is patient a suitable candidate for occupational rehabilitation? Patient Job ☐ Yes ☐ No ANY OTHER WORK ☐ Yes ☐ No

(b) When could trial employment commence? Date: _____ Patient's Job ☐ Full-time ☐ Part-time Date: _____ Any other work ☐ Full-time ☐ Part-time

REMARKS

(Limitations, Therapy, etc.)

Physician's Name (Print) | Degree | Telephone ( ) | Fax ( )

Street Address | City or Town | State or Province | Zip Code

Signature | Date

EMPLOYER'S REPORT OF CLAIM

TO BE COMPLETED BY EMPLOYER

CLAIMANT

1. Employee Name:

2. Social Security No.

3. Date of Birth

4. Occupation at time last worked

5. Work schedule at time last worked No. of days per week _____ No. of hours per day _____

6. Employee's Date of Hire

7. Date employee was actually last present at work

8. Has employee returned to work? ☐ Yes ☐ No ☐ Part-time Date: _____ ☐ Full-time Date: _____

EMPLOYER

9. Employer Name

10. Date

11. Signature

12. Title

13. Name (Please Print or Type)

14. Telephone ( )

15. Address

16. City, State, Zip

17. Fax ( )

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ATTENDING PHYSICIAN'S STATEMENT - ACCIDENTAL DEATH

Please complete if claim is for loss of life.

Name of Deceased	Age at Death

Residence at Time of Death (Number and Street)	(City, State)	(Zip)

Date of Death	Place (if in hospital or institution, give name)

Cause of Death (Including ICD Codes)

Was Death Due To: ☐ Accidental Bodily Injury ☐ Homicide ☐ Other (Give details in Remarks section)

Give Details and Date

Were there any contributing causes of death? Give the dates and duration of each as closely as you can.

Was there an autopsy, inquest, or post mortem examination? By whom?

Remarks:

_____

_____

_____

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician's Signature	**Date**

Physician's Name	**Degree**

Address	**Telephone ( )**	**Fax ( )**

City	**State**	**Zip**

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CLAIMANT: PLEASE REMEMBER

1. To complete ALL questions and sign Insured's Statement.
2. To obtain the investigating officer's report if loss due to motor vehicle accident or homicide.
3. To attach a CERTIFIED copy of the death certificate.