

# Family Heritage Life Insurance Company of America

P.O. Box 470608 Cleveland, Ohio 44147

Please read the following information before completing this form.

**WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive 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.

**Arkansas, Louisiana, Rhode Island, Texas and West Virginia:** 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.

**Alaska:** 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.

**Arizona:** 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.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** 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.

**District of Columbia: 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:** Any person who knowingly or 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.

**Hawaii:** For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Indiana:** Any 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.

**Kentucky:** Any person who knowingly or 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.

**Maine:** 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.

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

**New Hampshire:** 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.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** 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.

**Ohio:** 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.

**Oklahoma: 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.

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

**Pennsylvania:** 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, Virginia and Washington:** 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.

# 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 is 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 90 days 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