AMERICAN PUBLIC LIFE INSURANCE COMPANY

P.O. BOX 925, JACKSON, MISSISSIPPI 39205-0925 • (601) 936-6600 or 1 (800) 256-8606

Policy Nos.: ____________

S.S.#: ____________

CLAIMANT'S STATEMENT: Complete for all claims.

Policyholder's Name: ____________ S.S.#: ____________ Date of Birth: ____________

Address: ____________ Home Phone ( ) ____________

Employer: ____________ Occupation: ____________

Answer if Claim is on Dependent

Dependent's Name: ____________ Relationship: ____________

Date of Birth: ____________ S.S.#: ____________

Is Dependent Employed? ☐ Yes ☐ No Employer: ____________

Is Dependent a Student? ☐ Yes ☐ No School: ____________

IMPORTANT: SUBMIT A COPY OF THE POLICE REPORT IF THIS CLAIM IS DUE TO A VEHICLE ACCIDENT.
SUBMIT A COPY OF THE PATHOLOGY REPORT IF THIS CLAIM IS DUE TO CANCER.

1. CLAIM IS FOR: ☐ Accident ☐ Illness ☐ Nature of Illness/Injury: ____________
2. Date of Accident or 1st Sign of Illness: ____________ If claim is for an Accident, describe how and where it occurred: ____________
3. Has claim been made or will claim be made under any Worker's Compensation or Employers Liability Law? ☐ Yes ☐ No
4. Were you hospitalized? ☐ Yes ☐ No If yes, give dates, from ____________ (Mo. Date Yr.) to ____________ (Mo. Date Yr.)

   Name/Address of Hospital: ____________

   If you were hospitalized, **send a copy of the hospital bill.**
5. List all the Doctors you have seen for this condition.

   Name Address Date 1st Seen

6. Have you ever had symptoms of this condition before? ☐ Yes ☐ No When: ____________
7. Do you have insurance with any other company? ☐ Yes ☐ No If yes, provide: ____________

   Name of Company Policy Number(s)

Complete this Section only if you are filing for disability (loss of time from work) benefits. **NOTE: FAXED CLAIM FORMS ARE NOT ACCEPTED FOR DISABILITY CLAIMS. THE ORIGINAL FORM IS REQUIRED.**

1. Date you stopped working due to disability: ____________ Date you returned, or will return, to work: ____________
2. Are you confined (restricted by Drs. Orders) to your home? ☐ Yes ☐ No
3. Average Monthly Earnings? $____________
4. List Job Duties: ____________

AR and **LA**: 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. **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** and **NV**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information concerning a material fact is guilty of insurance fraud. In **IN** insurance fraud is a felony. In **NV** insurance fraud is a category d felony. **KY**: 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. **NM**: Any person who knowingly presents 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 and confinement in prison. **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. **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. **OR**: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law. **TN**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. **VA**: 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. **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 the above information is true and CORRECT to the best of my knowledge.

Policy Owner Signature: ____________ **Claimant Signature:** ____________ **Date:** ____________

THIS CLAIM REPORT IS USED FOR ANY TYPE OF HEALTH CLAIM AND MUST BE RETURNED TO
AMERICAN PUBLIC LIFE INSURANCE COMPANY, P.O. BOX 925, JACKSON, MISSISSIPPI 39205-0925, PHONE 800-256-8606

EMPLOYER'S STATEMENT: Must be completed for disability benefits.

1. Date of first absence due to disability: ______________ Date employee returned or will return: ______________
2. Date hired: ______________ Date of termination if Employee is terminated: ______________
3. Date of retirement if Employee is retired: ______________ Did Employee take disability retirement? ______________
4. **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? ______________
5. Has claim or will claim be made for Worker's Compensation Benefits? ______________ If "yes", what is status of the claim? ______________
6. Will you provide "light duty" if employee is released with restrictions? ______________

Name of Employer: ______________ Phone number of Employer: ______________

Authorized Signature: ______________ Title or Position: ______________ Date: ______________

PART B 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. Please provide ICD-9 codes. *(If diagnosis code other than ICD used, give name)*
2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
3. If condition is due to an accident, please give details of the accident.
4. Is condition due to pregnancy? ☐ Yes ☐ No If Yes, expected date of delivery: ______________ Date of LMP: ______________
5. Report of services (or attach itemized bill). If a previous form has been submitted to this carrier, you need to show only dates and services since last report.

Date of Services (Mo., Day, Yr.)	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code – If used (If code other than CPT used, give name)	Charges

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 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 ______________ To ______________
    Patient was house confined: From ______________ To ______________
    (House confinement is the inability to leave the house except to obtain medical treatment or to engage in medically prescribed activities that are therapeutic in nature).
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): ______________ IRS Identification No.* : ______________

Physician's Signature: ______________ Degree: ______________ Date: ______________

Address: ______________

Street City State or Province Zip Phone Number (include area code)

* THE INSERTION OF THE IRS NUMBER IS REQUIRED BY THE INTERNAL REVENUE SERVICE.

American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive, Jackson, Mississippi 39232
(601) 936-6600 • (800) 256-8606

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any physician or practitioner of the healing arts, hospital, clinic or medically related facility, pharmacy, insurance company, health maintenance organization, medical information bureau, Worker's Compensation carrier, Social Security office, Veterans Administration, retirement system, government entity (federal, state or local) or other organization, institution or person to release any information regarding the medical or mental health history, treatment, disability or benefits payable for medical care or disability to the American Public Life Insurance Company or its representative. A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed, except release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from date signed. I understand that this authorization may be revoked at any time by providing written notice to American Public Life Insurance Company ***except to the extent that American Public Life has taken action in reliance of this authorization or to the extent that law allows American Public Life to contest claims or coverage. Written notice must refer to the authorization by indicating the date it was signed and should be mailed to APL Claims Department, P O Box 925, Jackson MS 39205-0925.*** By signing below I certify the above information as true and CORRECT to the best of my knowledge.

American Public Life may use this information to determine what, if any, benefit can be provided for any American Public Life coverage for which I may be eligible.

By State Law, you must be advised that:
THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").

The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing (but not psychotherapy notes) and treatment records of alcohol and drug abuse.

You do have the right to refuse to sign this authorization; however, failure to sign the authorization may result in a denial of benefits.

American Public Life Insurance Company and its reinsurers agree to maintain the confidentiality of all the Insured's nonpublic financial or medical information given to us by any authorized entities listed above*;* ***however, federal law (HIPPA) requires you be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected by HIPPA rules.***

Signature:________________________________ Date: ____________________

Print Your Name:________________________ Name of Claimant:____________________

If a personal representative signs this authorization, a description of the authority to act on behalf of the Insured must be included.

RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR PERSONAL RECORD.