ASSURANT Health®

Accident Medical Expense Coverage Claim Form

To file your Accident Medical Expense claim with Assurant Health, please follow these steps.

1. Complete sections 1, 2, 5 and either sections 3 or 4 of this form.

2. Include the following documentation:
   - Fully itemized bills containing diagnosis and procedure codes from the doctors and facilities you used
   - Explanations of benefits (EOBs) for treatment of the accident from any other insurance carrier (note: you do not need to send EOBs from Assurant Health medical insurance)
   - Accident or incident report, if applicable, or police report for automobile accidents
   - Emergency room notes/discharge paperwork, if applicable
   - Operative report for surgical claims, if applicable

3. Send this form and the required documentation to this address or fax number:

Assurant Supplemental Coverage Accident Medical Expense claims
PO Box 2829
Clinton, IA 52733-2829
Fax 608.373.9503

If you have questions about this form, please call 866.387.0484.

SECTION 1: INJURED PARTY INFORMATION

Last name	First name	MI	
Address	City	State	ZIP

Accident Medical Expense Coverage policy number	Social security number (optional)	Phone number (day)	Phone number (evening)

SECTION 2: SPECIFIC ACCIDENT INFORMATION

Date of accident	Date of initial medical treatment	Was the accident work related? Yes ☐ No ☐	Was the accident covered by Workers' Compensation? Yes ☐ No ☐

If the accident was due to an automobile accident, was the injured party ☐ Driver ☐ Passenger
Please include a copy of the incident or police report, if applicable

Please give the specific details of the accident, including how it occurred, what transpired and when.

SECTION 3: OTHER INSURANCE INFORMATION
Please complete this section if you have other insurance.

Aside from your Accident Medical Expense plan, do you have any other Assurant Health medical plans? Yes ☐ No ☐
If yes, please provide the policy number(s).

If you have insurance from any carrier other than Assurant Health that will pay for this accident, please provide that policy information here.

Carrier 1 company name	Type of policy	Policy number
Carrier 2 company name	Type of policy	Policy number

SECTION 4: CERTIFICATION OF NO OTHER INSURANCE FOR THIS CLAIM
Please complete and certify this section by signing below only if you have no other medical or accident insurance that will pay for the amounts requested in this claim.

I certify that no other insurance will pay for this claim, I certify that this accident will not be paid for by any of the following:

- A self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (ERISA)
- Individual or group disability or health insurance coverage, including short-term limited duration health coverage or limited medical expense plans
- Individual or group health plan coverage, including HMO, capitation-arrangement, pre-paid or service-basis plans
- Worker's compensation protection by any name
- Hospital, other fixed-indemnity or any other supplemental coverage
- Medical coverage under a motor vehicle insurance contract
- Medicare Part A or Part B or military-sponsored health care
- Medical care program of Indian Health Service or of a tribal organization
- State health benefit risk pool
- Federal Employee Health Benefit Plan (FEHBP)
- Any public health plan
- Church plan or benefits received from a service organization
- Health plan under the Peace Corps Act

Signature of injured party (if minor, parent must sign and state relationship)	Date

SECTION 5: HIPAA AUTHORIZATION

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me to provide all such information as may be requested by Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including but not limited to EMSI.

This authorization includes any and all information you have about me, including but not limited to information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information also may be disclosed to any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as the original.

I understand that this authorization is required in order to enable Time Insurance Company to make payment determinations relating to me and/or my minor children. I may refuse to sign this authorization; however, Time Insurance Company may not be able to make a payment determination without the required information.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to Privacy Office, Assurant Supplemental Coverage, PO Box 2829, Clinton, IA 52733-2829. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires when I am no longer a policyholder of Time Insurance Company.

Signature of injured party or representative*	Date

*If you are the injured party's representative but are not the legal guardian, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A COPY FOR YOUR RECORDS.

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 is subject to criminal and civil penalties.