

## Claim Forms & Instructions

### 1. **CANCER**

Use claim form C101.

Complete the section entitled "Claimant's Statement". Be sure to date and sign the blanks provided at the bottom of the form.

A pathology report diagnosing cancer **must** accompany the first claim for that diagnosis of cancer. (The hospital or doctor will furnish this report at the patient's request.) If the diagnosis of cancer was made by clinical information instead of pathological means, the clinical evidence that established the diagnosis of cancer must be submitted.

Submit completely itemized bills for hospitalizations, surgery, anesthesia, chemotherapy and radiation therapy, etc.

For transportation benefits, a statement of the mileage from the employee's legal residence to the place of treatment should be obtained from the local law enforcement agency or ambulance service.

Claims should be mailed to American Public Life, P. O. Box 925, Jackson, MS 39205-0925. For questions, call 800-256-8606.

# 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* Dependent's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

*Claim is on* Date of Birth: \_\_\_\_\_ S.S.#: \_\_\_\_\_

*Dependent* 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 1<sup>st</sup> 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 \_\_\_\_\_ to \_\_\_\_\_  
Mo. Date Yr. 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 1<sup>st</sup> 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: \_\_\_\_\_





# 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.**