Union Security Insurance Company

P.O. Box 977122, Miami, FL 33197-7122 • 1.800.327.5288 • Fax 305.252.6910
Attn: DFS Claims Department

ACCIDENTAL BENEFITS CLAIM FORM

Mail or fax completed form and any attachments to 305.252.6910.
After mailing your claim, please allow 15 business days for processing.

INSTRUCTIONS

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed.)

DEATH

- ☐ 1. Complete Section 1. (To be completed by person reporting the claim.)
- ☐ 2. Have Creditor or Financial Institution where the coverage was purchased complete Section 3.
- ☐ 3. Attach a copy of Application and Certificate of Insurance.
- ☐ 4. Attach a copy of certified Death Certificate (and if applicable, Guardianship papers for minor beneficiary).
- ☐ 5. If you are the spouse of the deceased, attach proof of enrollment and payment of tuition in professional or trade training program or educational degree program (if applicable).

DISMEMBERMENT/INJURY

- ☐ 1. Complete Section 1.
- ☐ 2. Have Doctor complete Section 2.
- ☐ 3. Have Creditor or Financial Institution where the coverage was purchased complete Section 3.
- ☐ 4. Attach a copy of Application and Certificate of Insurance.
- ☐ 5. Attach a copy of Hospital Bill - UB82 Form, showing admission and discharge dates with diagnosis (if applicable).
- ☐ 6. Attach copy of Ambulance Bill (if applicable).

DEPENDENT CARE

- ☐ 1. Complete Section 1. (To be completed by person reporting the claim.)
- ☐ 2. Have Creditor or Financial Institution where the coverage was purchased complete Section 3.
- ☐ 3. Attach a copy of certified Death Certificate.
- ☐ 4. Attach a copy of the certified birth certificate or Placement Agreement or final adoption decree.
- ☐ 5. Attach proof of enrollment and payment of tuition for school or day care.

AZ residents only: 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.

CA residents only: 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.

CO residents only: 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.

DC residents only: 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.

For Florida Only - Pursuant to § 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in § 775.082, § 775.083, or § 775.084, Florida Statutes.

KY residents only: Any person who knowingly and with intent to defraud any insurance company, or other person files a claim for insurance 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. **HIGH LIMIT AD** - No statements made by the applicant may be changed without his written consent.

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

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

NM residents only: 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.

SECTION 1 - CLAIMANT'S INFORMATION (TO BE COMPLETED BY PERSON REPORTING THE CLAIM) PLEASE PRINT

POLICY NUMBER			EFFECTIVE DATE OF POLICY / /
FULL NAME OF CLAIMANT	OCCUPATION		TELEPHONE NUMBER ( )
STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE
NAME OF EMPLOYER	TELEPHONE NUMBER ( )	EXTENSION	FAX NUMBER ( )
STREET ADDRESS	CITY	STATE	ZIP CODE

ORIGINAL DATE OF ACCIDENT / /	DATE OF DEATH OR DISMEMBERMENT / /	WAS THE DEATH OR DISMEMBERMENT JOB RELATED ☐ Yes ☐ No

WAS TRANSPORTATION BY AMBULANCE REQUIRED

☐ Yes ☐ No **If yes, attach a copy of Ambulance Bill**

DESCRIBE HOW AND WHERE ACCIDENT OCCURRED

DESCRIBE INJURIES

WITNESSES TO ACCIDENT

NAME	STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE
NAME	STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE
NAME	STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE

WAS ACCIDENT REPORTED TO POLICE ☐ Yes ☐ No	IF YES, NAME AND ADDRESS OF POLICE DEPARTMENT

CLAIMANT, BENEFICIARY OR NEXT OF KIN AUTHORIZATION

I AUTHORIZE any employer, physician, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsurance company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or the organization or person having any records, data, or information concerning this claim to furnish such records, data, or information to the insurance company issuing my policy. I understand that in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. I expressly consent to the release of information as designated above.

The above information is true and correct. If, in fact, the furnished information is false, thereby inducing payment of claim, and the insurance company issuing my policy determines that the incorrect information constitutes an aiding and abetting the filing of a fraudulent claim, the insurance company issuing my policy may furnish the above information to the appropriate state authorities to be used in its discretion as the basis for action authorized under applicable state law. In addition, I agree any statements made on this or any other form found to be false shall give the insurance company issuing my policy the right to void my policy.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall be valid for the duration of the claim.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties. **For other Fraud Statements see Pages 1 and 3.**

NAME OF CLAIMANT OR PERSON REPORTING CLAIM (PLEASE PRINT)	SIGNATURE X	DATE OF BIRTH / /	RELATIONSHIP TO DECEASED	DATE OF BIRTH / /
STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

SECTION 2 - STATEMENT OF ATTENDING PHYSICIAN

PLEASE PRINT

PATIENT'S FULL NAME	DATE OF BIRTH	AGE
	/ /	

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)	DIAGNOSIS CODE(S)
	☐ ICD-9_____ ☐ CPT_____ ☐ DSM III_____

WAS INJURY DUE TO AN ACCIDENT	IF YES, DATE OF ORIGINAL ACCIDENT	FIRST DATE OF TREATMENT
☐ Yes ☐ No	/ /	/ /

WAS PATIENT COMATOSE AS A RESULT OF ACCIDENT	WAS SURGERY PERFORMED
☐ Yes ☐ No If yes, FROM / / TO / /	☐ Yes ☐ No

IF YES, DESCRIBE SURGERY	DATE PERFORMED
	/ /

INDICATE ANY MEDICAL CONDITIONS CONTRIBUTING TO THE INJURY OR DISMEMBERMENT

WAS PATIENT HOSPITALIZED OR RECEIVED EMERGENCY ROOM CARE	WAS INSURED CONFINED IN ICU OR CCU
☐ Yes ☐ No FROM / / THROUGH / /	☐ Yes ☐ No FROM / / THROUGH / /

NAME OF HOSPITAL

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

PROGNOSIS/COMMENTS (HAS PATIENT PROGRESSED)	BLOOD PRESSURE (LAST VISIT)
	____/____ SYSTOLIC/DIASTOLIC

COMPLETE IF APPLICABLE

IS LOSS OF VISION ENTIRE AND IRRECOVERABLE	IF YES	INDICATE WHICH EYE(S) INVOLVED
☐ Yes ☐ No	☐ One Eye ☐ Two Eyes	☐ OD ☐ OS

WAS THERE SEVERANCE OF HAND ABOVE WRIST OR FOOT ABOVE ANKLE	IF YES
☐ Yes ☐ No	☐ One Limb ☐ Two Limbs ☐ Rt. Foot ☐ Left Foot ☐ Right Hand ☐ Left Hand

"I hereby certify that the above-described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

PHYSICIAN'S NAME (PRINT NAME)	PHYSICIAN'S SIGNATURE	DEGREE	MEDICAL I.D. NUMBER	DATE
	X			/ /

FORM MUST BE FULLY COMPLETED AND SIGNED OR STAMPED BY DOCTOR'S OFFICE.

SECTION 3 - CREDITOR'S STATEMENT (TO BE COMPLETED BY FINANCIAL INSTITUTION OR AGENT)

PLEASE PRINT

ACCOUNT NUMBER	CERTIFICATE NUMBER	EFFECTIVE DATE OF INSURED'S COVERAGE	INSURED TOTAL MONTHLY PAYMENT AT ONSET OF DISABILITY
		/ /	$

MONTHLY PREMIUM	PREMIUM PAID THROUGH DATE	PREVIOUS CLAIM NUMBER
	/ /	

NAME OF FINANCIAL INSTITUTION	TELEPHONE NUMBER	EXTENSION	FAX NUMBER
	( )		( )

STREET ADDRESS	CITY	STATE	ZIP CODE

NAME OF PERSON COMPLETING THIS SECTION (PLEASE PRINT)	SIGNATURE	DATE
	X	/ /

OK residents only: 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 residents only: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to denial of insurance benefits, fines and confinement in prison.

PA residents only: 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.

RI residents only: 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.

TX residents only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VA residents only: *This notice is not applicable to life and health insurance.

WA residents only: 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.

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Authorization for Release of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) requires us to get your written permission to obtain specific health information about you. We are requesting this information in order to process the claim you are presenting to our company. Therefore, please complete in detail, sign, date, and return the following form to us. We cannot process your claim until we have this form returned to us.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY

I hereby authorize the medical providers listed below to release the following information to Union Security Insurance Company.

INSURED INFORMATION

NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	DAYTIME TELEPHONE NUMBER
	- -	/ /	( )

STREET ADDRESS	CITY	STATE	ZIP CODE

MEDICAL PROVIDER (doctor, hospital, etc.) WHO I AUTHORIZE TO RELEASE MY PERSONAL INFORMATION

NAME	TELEPHONE NUMBER
	( )

STREET ADDRESS	CITY	STATE	ZIP CODE

DESCRIPTION OF INFORMATION TO BE RELEASED

ENTIRE MEDICAL RECORD	HIV/AIDS TEST RESULTS OR DIAGNOSIS AND TREATMENT
☐ ☐ Yes No	☐ ☐ Yes No

OTHER

I UNDERSTAND THAT:

a. This Authorization may be revoked by me at any time by writing to the company and clearly stating that I wish to revoke this Authorization.
b. 1. This Authorization will expire without any action by me one year after the date of my signing below.
   2. This Authorization shall be valid for the duration of the claim (**Arizona residents only**).
c. Revocation will not apply to my insurance company when the law provides my insurance company the right to contest a claim under my policy.
d. This authorization is voluntary and I have the right to refuse to sign it.
e. If I revoke this information, it will not apply to information that has already been released prior to my revocation.
f. Information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
g. Information released by this authorization may be subject to redisclosure by the recipient and may not be protected any longer by the HIPAA Privacy Rule.
h. I agree that a photocopy of this authorization shall be as valid as the original.
i. I, or my authorized representative, have the right to receive a copy of this authorization.

YOUR SIGNATURE (INSURED OR LEGAL REPRESENTATIVE)	DATE
X	/ /

AND if signing on behalf of a minor or as legal representative of another:

NAME OF PERSON YOU ARE SIGNING FOR (PROOF OF YOUR AUTHORIZATION MAY BE REQUIRED)

ONE FORM MUST BE COMPLETED FOR EACH MEDICAL PROVIDER

Please photocopy this form if you need additional copies.