American Bankers Life Assurance Company of Florida

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

DISMEMBERMENT CLAIM FORM

Mail or fax completed form and any attachments to 305.252.6910.

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.)

1. Complete Section A.
2. Complete attached Health Insurance Portability and Accountability Act (HIPAA) Authorization.
3. Have attending physician complete Section B.
4. Attach Certificate of Insurance and application.
5. Follow creditor's instructions for mailing completed claim form.

FAILURE TO COMPLETE REQUIRED SECTIONS AND PROVIDE REQUESTED DOCUMENTATION WILL DELAY PROCESSING OF YOUR CLAIM.

- **To avoid late fees, continue to make your monthly payments.**
- After mailing your claim, please allow 15 business days for processing.

CA residents only: For your protection California law requires the following to appear on this form: 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.

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.

FL residents 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.

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.

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.

A. CLAIMANT'S INFORMATION

PLEASE PRINT

ATTACH A COPY OF CERTIFICATE OF INSURANCE AND APPLICATION.

POLICY NUMBER				EFFECTIVE DATE OF POLICY / /
FULL NAME OF CLAIMANT	OCCUPATION			TELEPHONE NUMBER ( )
STREET ADDRESS/APT #	CITY	STATE	ZIP CODE	CLAIMANT'S EMAIL ADDRESS (IF AVAILABLE)
NAME OF EMPLOYER	TELEPHONE NUMBER ( )		EXTENSION	FAX NUMBER ( )
STREET ADDRESS/APT #	CITY			STATE / ZIP CODE
ORIGINAL DATE OF ACCIDENT / /	DATE OF DISMEMBERMENT / /			WAS THE ACCIDENT JOB RELATED ☐ Yes ☐ No

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'S AUTHORIZATION

I AUTHORIZE any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Internal Revenue Service, or other organization, or person having any records, data or information concerning this claim to furnish such record, 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 as it pertains to the processing or investigation of my claim(s). 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 page 1.**

CLAIMANT'S SIGNATURE	DATE	DATE OF BIRTH
X	/ /	/ /

B. STATEMENT OF ATTENDING PHYSICIAN

PLEASE PRINT

PATIENT'S FULL NAME	DATE OF BIRTH	AGE
	/ /	

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

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

IF YES, DESCRIBE SURGERY	DATE PERFORMED
	/ /

INDICATE ANY MEDICAL CONDITIONS CONTRIBUTING TO THE DISMEMBERMENT

COMPLETE IF APPLICABLE

IS LOSS OF VISION ENTIRE AND IRRECOVERAGLE	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 ☐ Lt Foot ☐ Rt Hand ☐ Lt 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 ID NUMBER	DATE
	X			/ /

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

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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.

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.