Accidental Dismemberment Claim Statement

ASSURANT Employee Benefits®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:
A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

If you live in the states of Arizona or New Jersey, the following statement applies to you:
A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island, the following statement applies to you:
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.

If you live in the state California, the following statement applies to you:
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.

If you live in Colorado, the following statement applies to you:
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 insur- ance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you:
WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee, or Virginia, the following statement applies to you:
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.

If you live in New Hampshire, the following statement applies to you:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Assurant Employee Benefits Group Life Benefits PO Box 973050 El Paso Texas 79997-3050
● T 800.451.4531 ● F 816.556.7687 ● LifeClaims@assurant.com www.assurantemployeebenefits.com

If you live in New York the following statement applies to you:
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 act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If you live in Minnesota, the following statement applies to you:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

If you live in Texas, the following statement applies to you:
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.

If you live in a state other than mentioned above, the following statement applies to you:
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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Insured Employee Instructions for filing an Accidental Dismemberment Claim

1. Complete Parts 1 and 4.
2. Complete Part 2 or Part 3 if filing for a dependent.
3. Have the employer complete Part 5.
4. Have the physician complete Part 6.
5. Sign and date the HIPAA Authorization.
6. Complete the Tax Information Certification.

HIPAA Authorization for Release of Protected Health Information – Life

ASSURANT Employee Benefits

Insured/Member name _____ SS _____

Address _____ City _____ State _____ Zip code _____

Individual who is the Subject of Protected Health Information _____

Policy no. _____ Participation _____ Account _____ Certificate _____

Persons/categories of persons providing the information: Entities possessing the information identified below, including physicians, any provider of medical services, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of the Individual referenced above.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of protected health information regarding the Individual referenced above, as described below:

Description of information to be disclosed: Records concerning medical advice, care or treatment. This may also include, but is not limited to: information relating to use of drugs or use of alcohol; post-mortem examination reporting, including autopsy, toxicology and investigation reports; accident reports made by ambulance, law enforcement and paramedics; other insurance carriers or a prior life insurance carrier or life insurance policy and related claim information; and financial or employment-related information.

The sole purpose of this disclosure is for the adjudication of a claim for life insurance benefits under the Policy referenced above.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- The authorization is effective from the date signed below until a final adjudication of the claim for life insurance benefits is reached or 24 months from date of signature, whichever comes first.

_____ _____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of personal representative _____

Relationship to insured/member _____

(e.g. LEGAL GUARDIAN, EXECUTOR, ADMINISTRATOR, OR NEXT-OF-KIN)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please make a copy of the signed Authorization for your records.

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ASSURANT Employee Benefits

Accidental Dismemberment Claim Statement

Part 1 – To be completed by Insured Employee *(Please print or type.)*

Full name *(As it appears on your Social Security card.)*		Policy number
Employer name		Employer phone number ☐
This claim is being filed for: ☐Self ☐Spouse ☐Dependent Marital status: ☐Married ☐Single ☐Divorced ☐Widow		Sex: ☐Male Female
Date of birth	Social Security number	Home phone number
Street address	City	State / Zip
Mobile phone number	E-mail address	

Did injury result from employment? ☐Yes ☐No ☐Currently disputed

Part 2 – Complete if benefits are for spouse *(Please print or type.)*

Full name (As it appears on his/her Social Security card.)		Sex: ☐Male ☐Female
Date of birth	Social Security number	Mobile phone number

Did injury result from employment? ☐Yes ☐No ☐Currently disputed

Part 3 – Complete for dependent if benefits are for dependent *(Please print or type.)*

Full name (As it appears on his/her Social Security card.)			Sex: ☐Male ☐Female
Date of birth	Married? ☐ Yes ☐ No	Social Security number	Mobile phone number

If over age 19, but less than 25, full-time student? ☐ Yes ☐ No
If "Yes," attach copy of recent semester grade report.

Name of school		School administration phone
Street address	City	State / Zip

Did injury result from employment? ☐Yes ☐No ☐Currently disputed

If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority and sign below.

Signature _____ Relationship to claimant _____

Part 4 – Claim Information*(Please print or type. If necessary, attach separate sheet.)*

Date of accident	Time of accident

Description of accident (*Attach police report or newspaper clipping if applicable*)

Primary physician name and address	Phone
Hospital name and address	Phone

Part 5—To be completed by Employer

1. Full name of insured (*Please print.*)	2. Certificate number	3. Effective date of insurance

4. Date employed	5. Date last worked	6. Reason for not working after this date

7. Occupation, position or title	8. Basic salary rate as of the determination date specified in the policy. $ per	9. Amount being claimed (1/2 dismemberment coverage) $

10. Was insurance in force when injuries were sustained?
☐Yes ☐No (If "No," give date and reason for termination.)

11. Did injuries arise out of, or in the course of, the employment of the insured?
☐Yes ☐No (If "Yes," please explain.)

12. Have you any additional information relating to this claim?

13. We hereby certify that the above facts are true to the best of our knowledge.

Policy no. _____ Name of employer _____

Participation no. _____

Account no. _____ Branch or affiliate _____

AUTHORIZED SIGNATURE

IMPORTANT TAX INFORMATION

The Federal income tax laws require us to request that you provide us with your correct Social Security Number or Taxpayer Identification Number.

Please read and complete the following information in order to comply with the Federal income tax laws. See "Guidelines for Determining the Proper Taxpayer Identification Number" on the following page.

Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person, and
4. I am exempt from FATCA reporting.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Your Signature _____ Date _____

Please print your name _____

Note: Your signature as signed above will also be used to verify your signature for ProviderFund® Account Checks.

GUIDELINES FOR DETERMINING THE PROPER TAXPAYER IDENTIFICATION NUMBER

Social Security numbers have nine digits separated by two hyphens, i.e., 123-45-6789. Employer identification numbers have nine digits separated by one hyphen, i.e. 98-7654321. The guidelines below will help determine the number to give us.

1. **For an individual**
   Give the Social Security number of the individual.
2. **For a custodian account of a minor (Uniform Gifts to Minors Act)**
   Give the Social Security number of the minor.
3. **For an account in the name of a guardian for a designated ward, minor, or incompetent person**
   Give the Social Security number of the ward, minor, or incompetent person
4. **For a valid trust or estate**
   Give the Employer Identification number of trust or estate. *(Do not furnish the identification number of the personal representative or trustee.)*
5. **For a corporation, religious, charitable, or education organization**
   Give the Employer Identification number of the corporation or organization.

If you do not have a Social Security number or other taxpayer identification number, write "Applied For" in the space for the number, sign and date the form and return to Assurant Employee Benefits. You will have 60 days to obtain a Social Security or other taxpayer identification number and furnish it to us.

1. "Applied For" means you have already applied for **or** that you intend to apply for a Social Security or other taxpayer identification number soon.
2. You must complete this form even if you are exempt from Backup Withholding to avoid possible erroneous Backup Withholding.
3. If you are a foreign person, complete and submit to us the appropriate, IRS Form W-8.

ARE YOU EXEMPT FROM FATCA REPORTING?

You may be subject to FATCA reporting if you are submitting this form for an account maintained outside of the United States by certain foreign financial institutions. If you are submitting the form for an account you hold in the United States, no FATCA reporting is required. If you are a foreign person, complete and submit to us the appropriate IRS Form W-8. For additional information, see General Instructions to IRS Form W-9.

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

Part 6 – Physician's Statement - *This statement must be filled in completely by a physician. (Please print or type.)*

Was injury the result of any of the following?

☐ Attempted suicide ☐ Intoxication ☐ Use of drugs
☐ Committing a felony ☐ Self-inflicted ☐ Work-related
☐ Complication of treatment

Date of accident	Diagnosis	Date of diagnosis	ICD-9 code

Has this patient been treated for this same or similar condition prior to this occurrence? ☐ Yes ☐ No

If "Yes," please provide diagnosis, the dates of treatment and names of other medical providers.

Provide the name, address and phone number of any referring physicians.

For services related to a hospitalization, please provide the following. *(Please print or type.)*

Name of hospital

Street address of hospital	City	State	Zip	Phone

Admission date	Discharge date

5. As a result of this accident, did the patient suffer the loss of:

☐ Right hand? Give the anatomical location of
☐ Left hand? amputation and date performed.
☐ Right foot?
☐ Left foot?

☐ Sight of right eye?
☐ Sight of left eye?

Is loss of sight total and irrecoverable? ☐ Yes ☐ No

If "Yes," give date loss of sight became total and irrecoverable. Give details if sight can be restored to either eye.

6. Final diagnosis, including complications

7. Additional remarks

Physician's Information *(Please print or type.)*

Name	Degree	Specialty/Board Certification

Street address	City	State	Zip

Phone	Fax

Physician's signature	Date

DO NOT PRE-DATE