Atlantic American Employee Benefits
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7502
Email: groupclaims@atlam.com

Accelerated Death Benefit Claim Form

We understand this is a difficult time and we hope we can help alleviate any concerns you might have about your claim. Fortunately, you established a life insurance policy to help during this stressful time.

Complete this claim form if you are diagnosed as having a terminal illness, with a life expectancy of twelve months or less. This may qualify you to be eligible to receive a portion of your Life benefits which can help provide financial assistance and flexibility. We rely on the information you provide on the claim form to effectively determine if you qualify for benefits.

This guide provides information and instruction to help you successfully complete and submit the claim.

Important Tips for Submission

Prior to submission, make sure you have provided all the required information and answered all of the questions completely and accurately. If information is missing or cannot be read, the processing of your form could be delayed.

The following guidelines provide information to help you successfully complete the form.

Guidelines for Claim Form

This form should be completed by the covered insured. In order to be considered complete, the form must be signed by you or your legal representative.

- Policy number will consist of ten digits which will come after “005”
- Date First Treated is the date you first sought medical care.
- Medical records from your providers may be needed in order to make a determination on your claim. A completed authorization form will be needed to obtain them. To avoid any additional delays in the claim, please be sure to complete and submit the authorization forms with your claim application.

Authorization to Disclose Personal Information

This form should be filled out by the covered insured. In order to be considered complete, the form must be signed by you or your legal representative.

- By signing the authorization, you are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name on any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

(Continued on next page)

What documents do I need to submit if there is a legal representative?

- Power of Attorney Document
- Guardianship Document

Guidelines for Attending Physician Statement

This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.

Please mail these forms back to the following address:

Bankers Fidelity Life Insurance Company

Attn: Claims Operations Department

4370 Peachtree Road NE, Atlanta, Georgia 30319

If you need any immediate assistance, you may reach our Claims Operations Department at (866)-458-7502.

Claims Questions

Phone: 866-458-7502

Email: groupclaims@atlam.com

ATLANTIC AMERICAN
Employee Benefits

Mail To: **Bankers Fidelity Life Insurance Company®**
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7502

ACCELERATED DEATH BENEFIT CLAIM FORM

Has a Claim been filed before for this loss? .....❒ **Yes** ❒ **No**

Section 1 – Employee Information			
Name (First, Middle & Last)		Policy Number	
Date of Birth	Gender ❒ Male ❒ Female	SSN	
Address	City	State	Zip
Home Phone Number	Cell Phone Number		
Email Address			

Section 2 – Claimant Information			
Who is this claim for? ❒ Employee ❒ Spouse ❒ Child		If claim is for a child, is he/she a full-time student? ❒ Yes ❒ No	
Claimant Name (First, Middle & Last)			
Claimant Date of Birth	Claimant Age	Claimant SSN	

Section 3 – Accelerated Death Benefit Details	
Date Symptoms First Appeared/Accident Happened	
Details of Medical Condition Resulting in Illness	
Date Physician was First Consulted for Condition	Are you receiving in home care? ❒ Yes ❒ No

Claimant or Legal Representative Signature	Printed Name	Date
Irrevocable Beneficiary (if applicable)	Printed Name	Date

If the designated beneficiary on this policy is irrevocable, the signature is required in order to proceed.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records to Bankers Fidelity Life Insurance Company (Bankers Fidelity) containing the Personal Information of:

Name of Claimant (Last, First, Middle)	Date of Birth	Social Security Number

2. Personal Information to be released:
   - Data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - Any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - Any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. I understand my Personal Information will be used by Bankers Fidelity to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Bankers Fidelity to release my Personal Information as follows:
   - Other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - To vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - To my employer for use in discussions with Bankers Fidlity regarding my functional capacity, and any related restrictions and
   - Limitations, in order to facilitate my return to work; or
   - As otherwise required or permitted by law or as I further authorize

4. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

5. I understand that I may revoke this Authorization at any time by providing a written request to Bankers Fidelity at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Bankers Fidelity receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

Name(s) used for records (if different than the name above) _____ Signature of Claimant _____ Date _____

If Applicable

I am the Legal Representative of the person whose health information is to be disclosed, but I am authorized to grant permission on behalf of that person. If signing as Legal Representative, a copy of the executed Power of Attorney, Guardianship or other similar documents granting you the capacity to represent the insured or act on their behalf, must be submitted.

Printed Name of Legal Representative _____ Signature of Legal Representative _____ Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

NOTICE

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Alabama Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas Residents Only
WARNING: 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.

District of Columbia 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.

Florida Residents Only
WARNING: 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.

Louisiana Residents Only
WARNING: 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.

Maryland Residents Only
WARNING: 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 may be guilty of insurance fraud as determined by a court of competent jurisdiction.

Pennsylvania Residents Only
WARNING: 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.

Tennessee Residents Only
WARNING: 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.

Virginia Residents Only
WARNING: Any person who, with the 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 may have violated state law.

Washington Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

ATLANTIC AMERICAN
Employee Benefits

Mail To: **Bankers Fidelity Life Insurance Company®**
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7502

Answer all questions in order to avoid delays

Attending Physician Statement

To be completed by the treating physician or licensed health care practitioner who diagnosed/certified the illness/condition for which this claim is being filed.

Patient Name		Patient Date of Birth
In my professional opinion, the insured is terminally ill ❒ Yes ❒ No	Date First Consulted	Anticipated Life Expectancy (from the current date)
Diagnosis Codes		
Diagnosis Details		
Prognosis		
After a thorough, extensive medical review, I have concluded that the patient is terminally ill and is anticipated to survive ____ months.		
Date Symptoms Appeared or Incident Occurred	Name of Referring Physician	
Address of Referring Physician (Street, City, State & Zip)		Phone Number of Referring Physician
Additional Remarks		

Physician Name (Print) _____ Physician Signature _____ Date _____

Physician Address (Street, City/Town, State) _____ Telephone Number _____