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

Life Waiver of Premium Guidelines

A waiver of premium claim should be filed for an insured who has been continuously disabled for the length of time indicated in the policy. Premiums must continue to be paid during the waiver elimination period.

Note: Proof of disability must be received within one year of the start of the disability.

Guidelines for Claim Form

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

- Policy number will consist of ten characters which will come after “005”
- Job Title is the title of your position held with the Employer.
- The Hours Worked per Week is the number of hours you worked per week for the Employer.
- Date of Disability is the first day you were absent from work because of the disabling condition.
- Date First Treated is the date you first sought medical care because of the disabling condition.

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.

Guidelines for Employer’s Statement

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

- For an accident or injury related to on the job, a copy of the workers’ compensation report is required.

Guidelines for Attending Physician’s 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.
- The insured is responsible for any costs associated with completion of the attending physician statement.

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 assistance, you may reach our Claims Operations Department at (866) 458-7499
or by email: claims@atlam.com.

Claims Questions

Phone: 866-458-7502
Email: groupclaims@atlam.com

Mail To: **Atlantic American Employee Benefits**
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7502

LIFE WAIVER OF PREMIUM CLAIM FORM

Policyholder Information - to be completed by the insured	
Name (First, Middle & Last)	
Date of Birth	Social Security Number
Address (Address, City, State, Zip)	
Phone Number	Email
Specify the nature of the disability (if accident, include how, when and where accident occurred)	
Sickness	Date symptoms first appeared
Accident	Date of Accident
Provide your occupation	
From what date do you claim that the total disability has prevented you from performing your own occupation	
From what date do you claim that the total disability has prevented you from performing any occupation	
If now totally disabled, when do you expect to be able to return to work	

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EMPLOYER STATEMENT

(Answer all questions to avoid any delays)

TO BE COMPLETED BY EMPLOYER			
Company Information			
Company Name			
Address	City	State	Zip
Phone Number	Email Address		
Employee Information			
Employee Name	Phone Number		
Address	City	State	Zip
Employee's Job title	Employee's Date of Hire	Hours Worked per Week	
Gross Weekly Earnings	Was disability on the job? ❒ Yes ❒ No	Date of Disability	Date covered under STD plan
Has employee returned to work? ❒ Yes ❒ No	If "yes", date returned to work. If "no", expected return to work date.		
Total Disability: On what date was the employee totally disabled?	Partial Disability: On what date did the employee perform only partial duties?		

Printed name and title of representative completing this form ______

Signature of representative completing this form ______

Date ______

*Please notify Atlantic American if the employee returns to work after the submission of this form.

(Answer all questions in order to avoid delays)

ATTENDING PHYSICIAN STATEMENT

Physician Information

Patient Name	Patient Date of Birth

1. Diagnosis(es) ____________________

____

ICD-10 code(s) ____________________

2. How did condition(s) originate? ____________________

____

____

Date Symptoms First Appeared	Initial Date of Treatment	Last Date of Treatment	Next Date of Treatment

Patient disabled ❒ Own Occupation ❒ Any Occupation

Patient permanently disabled ❒ Own Occupation ❒ Any Occupation

How long was or will patient be continuously **totally disabled** (unable to return to work)? From ____________ To ____________

How long was or will the patient be **partially disabled**? From ____________ To ____________

Full Time ❒ Yes ❒ No | Part Time ❒ Yes ❒ No If yes, number of hours per day _______ Week ________

Did or will another physician treat the patient? ❒ Yes ❒ No	Date Treated/Treating	Name of Physician

1. What functions of the person's own/usual occupation is the person unable to perform? ____________________

____

2. What functional restrictions have been placed on this person? ____________________

____

______________________ Physician Name (Print) ______________________ Physician Signature ______________________ Date

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