ATLANTIC AMERICAN
Employee Benefits

Atlantic American Employee Benefits Claims Department

4370 Peachtree Road NE, Atlanta, Georgia 30319

Phone: (866) 458-7502

Email: groupclaims@atlam.com

A Guide for Successfully Completing the Group Accident Claim Form (On the Job Only)

Atlantic American Employee Benefits appreciates the opportunity to provide you with valuable protection. We rely on the information you provide on this form to effectively determine if you qualify for benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. You may also submit the claim online for a more expedited experience. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

What You Need to File a Claim

- Claim Form
- Authorization to Release Personal Information
- Attending Physician Statement
- Employer's Statement
- Proof of services (some examples below):
  - Emergency room, physician or urgent care report
  - Operative/surgical report
  - Scan/imaging report for major diagnostic imaging
  - HCFA 1500 (itemized non-hospital bill)/UB04 (itemized hospital bill)
  - Physician office notes

Guidelines for Claim Form

Section 1 – Employee Information

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

- Policy number will consist of ten digits 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.

Section 2 – Hospital/Physician Information

- Admission Date is the first day you were admitted as an inpatient to the facility.
- Discharge Date is the day you were discharged as an inpatient from the facility.
- Initial Date of Treatment is the date you first sought medical care because of the accident/injury/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.

Section 3 – Accident Claim

- Have your physician complete **Attending Physician Statement**
- Have your employer complete the **Employer's Statement** If the accident is due to an on-the job injury/accident
- Motor Vehicle Accident Report (if applicable) - If the injury was a result of an auto accident, you are required to submit a copy of the policy report.

Payment Method

- If no payment method is selected, a check will be mailed.

(Continued on next page)

Authorization to Disclose Personal Information

This authorization is to be completed by you, the Employee. Dates should include the month, day and year. In order to be considered complete, the form must be signed by you or your legal representative.

- 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.
- If the name associated with 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.

Guidelines for Employer's Statement

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

- 'Date Covered Under This Plan' indicates the date in which the Employee's coverage became effective.
- Please include copy of Employee's enrollment form, if applicable.
- For an accident or injury related to on the job, a copy of the workers' compensation report is required.

Guidelines for Attending Physician Statement

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

Submitting Your Claim

Email/Fax:

Email: claims@atlam.com
Fax: 404-926-4036

Mail:

Attn: Claims Department
4370 Peachtree Road NE
Atlanta, Georgia 30319

Claims Questions

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

Online Claim Submission or Claims Status

https://mycoverage.atlam.com/

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

ACCIDENT CLAIM FORM

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

Section 1 – Employee Information

Name (First, Middle & Last)	Policy Number	Job Title	Hours Worked per Week

Address	City	State	Zip

Home Telephone Number	Cellular Telephone Number	SSN

Email Address	Date of Birth

Section 2 – Hospital/Physician Information

Attending Physician Name (First, Middle & Last)	Hospital Name

Hospital Address	Hospital City	Hospital State	Hospital Zip

Hospital Telephone Number	Hospital Fax Number

Admission Date	Discharge Date	Initial Date of Treatment	Last Date of Treatment

Section 3 – Accident Claim

Name of Claimant (First, Middle & Last)	Patient Relationship (Employee, Spouse, Child)

Date of Accident/Injury	Injury/injuries Sustained	Did this accident/injury happen at work? ❒ Yes ❒ No

Please provide an exact description of the accident (including date, time, location, environmental conditions, etc.).

Section 4 – Payment Method

Payment method:

❒ Check ❒ Electronic Funds Transfer (EFT)

For EFT, complete the following bank information

Bank Name	Bank City	Bank State	Bank Zip

Bank Account Number	Bank Routing/Transit Number	Type of Account (*check only one*)
		❒ Checking ❒ Savings

Notice regarding electronic funds transfer: When you select electronic funds transfer as your payment method, we may receive and contribute customer account and payment account data to a third party consumer reporting agency to confirm the feasibility of a transaction to your account.

Section 5 – Payment Authorization and Signature

Payment Authorization

I understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that Bankers Fidelity Life Insurance Company®, d/b/a Atlantic American Employee Benefits (hereinafter referred to as "Atlantic American"), can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid. I further understand and agree that any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that Atlantic American has no obligation to retrieve those funds or make replacement payment(s) to me. I further understand and agree for myself, my heirs, executors and estate to indemnify and hold Atlantic American harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization. I further understand and agree that Atlantic American is not responsible for any bank charges or other costs associated with or arising out of this agreement. I further understand that if my bank is not able to accept EFTs, check(s) will be mailed to my residence. I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following Atlantic American's receipt of the notice.

Dated: _____ Signed: X_____

Fraud Warnings:

Before signing this form, please see next page, STATE EXCEPTION FRAUD WARNINGS, for the state where you reside, and the state where the group policy and certificate for which you are claiming a benefit were issued.

Signed: X_____ Dated: _____

STATE EXCEPTION FRAUD WARNINGS

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. *(Applicable for all other states.)*

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.

Alaska Residents Only
WARNING: 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.

Arizona Residents Only
WARNING: 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.

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.

Colorado Resident Only
WARNING: 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.

Delaware Residents Only
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

Idaho Residents Only
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana Residents Only
WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky Residents Only
WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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.

Maine 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland Residents Only
WARNING: 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.

Minnesota Residents Only
WARNING: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents Only
WARNING: 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.

New Jersey Residents Only
WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico 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 civil fines and criminal penalties.

Ohio 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 is guilty of insurance fraud.

Oklahoma 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.

Oregon Residents Only
WARNING: Any person who knowingly presents a false statement in an application for insurance or statement of claim may be guilty of a criminal offense and subject to penalties under state law.

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.

Rhode Island 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.

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.

Texas Residents Only
WARNING: 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.

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: 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.

West Virginia 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.

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Employee Benefits

ATLANTIC AMERICAN EMPLOYEE BENEFITS®

Attn: Claims Operations Department
4370 Peachtree Road NE, Atlanta, GA 30319

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By signing below, you acknowledge and consent to the use of your Personal Health Information (PHI) by Bankers Fidelity Life Insurance Company, d/b/a Atlantic American Employee Benefits, and its subsidiaries, affiliates, and related companies (collectively referred to as "Atlantic American"), for the purpose of evaluating claim benefits and payments. If you choose not to sign this Authorization, your claim for benefits may not be processed. You also authorize Atlantic American to release your Personal Information as follows:

- Individuals or organizations providing business, legal or insurance support services related to your claim(s). Vendors or consultants offering wellness, disability, or leave-related services as part of an employer-sponsored benefit plan. To your employer for discussions with Atlantic American regarding your functional capacity, and any applicable restrictions, or limitations, to facilitate your return to work; and/or as otherwise required or permitted by law.

I, the undersigned, authorize any covered entity or business associate to the use and/or disclose of Personal Health Information of:

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

Personal Health 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). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

The Personal Health Information to be released is requested for the following reason(s):

This protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite Insured's application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage Insured has or has applied for with the Atlantic American.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to Atlantic American. **If written revocation is not received, this authorization will remain valid until 24 months after the date signed**. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

Insured's Signature	Date

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	Date

THIS FORM IS FOR USE WHEN AUTHORIZATION IS REQUIRED AND COMPLIES WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY STANDARDS.

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Employee Benefits

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

EMPLOYER STATEMENT

(Answer all questions to avoid any delays)

TO BE COMPLETED BY EMPLOYER				
Company Information				
Company Name				
Address		City	State	Zip
Phone #		Email Address		
Employee Information				
Employee Name		Phone #		
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

Is disability due to:	Is disability work-related?	Has patient ever had same or similar condition?
❒ Accident/Injury ❒ Sickness	❒ Yes ❒ No	❒ Yes ❒ No

3. If applicable, list the surgicalsurgical code(s)/procedure(s) – describe fully and provide date(s), if any.

_____

If claim is due to pregnancy, please provide the information below:

Actual Date of Delivery	Actual Type of Delivery
	❒ Natural ❒ Cesarean

If any of the following questions are answered "Yes", provide the information to the right of the question

Was the patient treated in an emergency room? ❒ Yes ❒ No	Date Treated	Name of Hospital
Was the patient hospital confined? ❒ Yes ❒ No	Date(s) Confined	Name of Hospital
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ❒ Yes ❒ No	Date of Surgery	
Did or will another physician treat the patient? ❒ Yes ❒ No	Date Treated	
Attending Physician Name (First, Middle & Last)	Physician Telephone Number	

Physician Address	Physician City	Physician State	Physician Zip

Physician Name (Print) _____ Physician Signature _____ Date _____

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