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

Claims Questions

Phone: 866-458-7502

Email: groupclaims@atlam.com

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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.

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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.

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.

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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 _____