ATLANTIC AMERICAN
Employee Benefits

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

Accidental Death & Dismemberment Claim

Atlantic American Employee Benefits appreciates the opportunity to provide you with valuable insurance protection underwritten by Bankers Fidelity Life Insurance Company. We understand this is a difficult time and we hope we can alleviate some concerns you might have about your claim. We rely on the information you provide on the claim form to effectively determine if you qualify for benefits.

If the insured suffers an accident and meets the conditions for any of the benefits listed below, and if that benefit is included in the plan, an accidental dismemberment benefit or additional amount may be payable.

- Unavoidable exposure to the elements
- Limb/Digit amputation
- Entire and irrevocable loss of hearing in both ears
- Entire and irrevocable loss of speech
- Permanent and uncorrectable loss of vision in one or both eyes
- Complete, permanent and irreversible paralysis

Please note that this form may include benefits that are not part of your plan. Bankers Fidelity Life Insurance Company will review the claim in accordance with your specific plan provisions.

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 Submission

This form should be completed by the covered insured that suffered an accidental injury that resulted in a covered loss other than death. Dates should include the month, date and year. 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 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.
- Motor Vehicle Accident Report (if applicable)—If the injuries or death were the result of an auto accident, you are required to submit a copy of the police report. If motor vehicle accident resulted in death, a copy of the autopsy report is required.

Authorization to Disclose Personal Information

This form should be filled out by the claimant. Dates should include the month, date and year. 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 associated 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

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AD&D 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 – AD&D Details (Accidental Death and Dismemberment)

Date & time accident happened HH:MM tt	City & state accident happened
Details of accident	

Policyowner (if other than Policyholder)	Printed Name	Date
Beneficiary/Claimant 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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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.

NOTICE

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application fo 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 present false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, 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 fals information in an application for insurance is guilty of a crime and may be subject to fines and confinement in priso

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 material related to a claim was provided by the applicant.

Florida Residents Only
WARNING: Any person who knowingly and with intent to injury, defraud, or deceive any insurer files a statement of claim or a 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 fals information in an application for insurance is guilty of a crime and may be subject to fines and confinement in priso

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 insuranc 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 benefit

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 la .

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

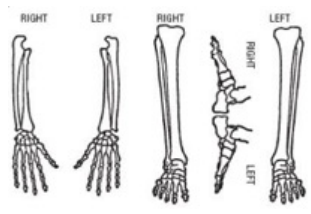
Attending Physician Statement

To be completed by the treating physician or licensed health care practitioner who diagnosed/certified the illness/condition for which you are filing this claim.

Patient Name		Patient Date of Birth
Date of accident causing present loss	Date First Consulted	Date of Last Treatment
Describe the exact nature, location, and extent of all injuries sustained		
Was the injury solely responsible for the loss? ❒ Yes ❒ No	If not, provide any contributing cause(s)	
In your professional opinion, was the loss caused in any way by illness? ❒ Yes ❒ No	If yes, what was the date you provided treatment for the illness?	

To be completed for limb/digit amputations

What limb/digit was amputated?	Date severance or amputation occurred
Describe the cause of the amputation	



State the exact point at which the amputation was performed or the severance occurred with respect to each limb/digit lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

Date of reattachment (if limb/digit was reattached)

Describe functional outcome of reattachment

To be completed for loss of vision	
Has the Patient had entire and irrecoverable loss of sight following the injury? ❒ Yes ❒ No	If yes, what date did you first determine vision was irrecoverably reduced to 20/200 or less with correction?
Date of last eye exam	Vision at last eye exam

	Uncorrected	Corrected
O. D. v		
O. S. v		

Describe the cause of loss of vision	
Will recovery or useful vision be possible by operation or treatment? ❒ Yes ❒ No	If yes, indicate below: O.D. ❒ Operation ❒ Treatment O.S. ❒ Operation ❒ Treatment

To be completed for loss of hearing	
Duration, in months, Patient had entire and irrecoverable loss of hearing following the injury	Date test results determined loss of hearing

Audiometry:

	Left Ear	Right Ear
	Uncorrected / Corrected	Uncorrected / Corrected
500 Hz	/	/
1,000Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

Describe the cause of loss of hearing

To be completed for loss of speech	
Duration, in months, Patient had entire and irrecoverable loss of speech following the injury	Date test results determined loss of speech

Describe the cause of loss of speech

Continued on next page

	Description Uncorrected	Corrected Method
Absence of vocalization structure(s)		
Evidence of obstruction		
Evidence of air passage defect		

Physician Name (Print) | Physician Signature | Date

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