ATLANTIC AMERICAN
Employee Benefits

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

Losing a loved one is one of the most difficult life events we ever have to face. Fortunately, your loved one established a life insurance policy to help provide you and your family the support you need during this stressful time.

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

What documents do I need to submit?

- Claim Form—Signed by the beneficiary/beneficiaries
- Certified Death Certificate
- Copy of obituary (if available)
- Physician and Authorization forms—Only required if death occurred within the first two (2) years of the policy issue date
- Police Report (if applicable)—Only required if the death was the result of an accident, suicide or homicide

What documents do I need to submit if the named beneficiary is deceased?

- Copy of the death certificate of named beneficiary; or
- Copy of obituary of the named beneficiary

What documents do I need to submit if beneficiary is a minor (under age 18)?

- Copy of Birth Certificate
- Probate Court Guardianship documents

What documents do I need to submit if the life proceeds are assigned to a funeral home?

- Assignment form provided by the funeral home

What documents do I need to submit if the claim is being paid to an estate or a trust?

- Letters of testamentary
- Letters of administration
- Other qualifying legal documents issued by the probate court
- Copy of the trust documents (if applicable)

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) 458-7502.

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Mail To: **Atlantic American Employee Benefits**
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LIFE CLAIM FORM

Policyholder Information		
Name of Deceased (First, Middle & Last)		
Policy #	Date of Birth	Date of Death
Manner of Death ❒ Natural ❒ Accidental ❒ Suicide ❒ Homicide		

Beneficiary/Claimant Information	
Name of Beneficiary (First, Middle & Last)	Relationship to Deceased
Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Email Address	Beneficiary Phone Number
Beneficiary Address (Address, City, State, Zip)	

Funeral Home (if applicable)	
Name of Funeral Home	
Funeral Home Address (Address, City, State, Zip)	Funeral Home Phone Number

Trustee (if applicable)	
Name of Trustee (First, Middle & Last)	
Tax ID of Trustee	Trust Agreement Date

Beneficiary or Trustee Signature	Printed Name	Date
Legal Representative of the Estate Signature (if applicable)	Printed Name	Date

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 injury, 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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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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Medical Information Request Form

INSURED NAME (First, Middle & Last)	**POLICY/CERTIFICATE NUMBER**

Please provide the names, complete addresses and telephone numbers of all physicians, hospitals and pharmacies who have treated or dispensed medication to the insured within the last 5 years in the area below.

1. PRIMARY CARE PHYSICIAN	Telephone Number
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____
2. PHARMACY NAME	Telephone Number
Street Address	
(City, State & Zip Code)	
3. HOSPITAL/CLINIC	Telephone Number
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____
4. NURSING HOME	Telephone Number
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____

5. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

1. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
2. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
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Street Address		Date First Seen Mo. _____ Yr. _____
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4. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
5. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

*If additional space is required please use a separate sheet of paper. The more complete the information the quicker we will be able to conclude our review.