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 insu ed 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 we e absent from work because of the disabling condition.
- Date First Treated is the date you first sought medical ca e 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

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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 <u>your own</u> occupation	
From what date do you claim that the total disability has prevented you from performing <u>any</u> occupation	
If now totally disabled, when do you expect to be able to return to work	

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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

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

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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.