

DETAILED INSTRUCTIONS ARE ATTACHED

- Part I** ♦ To be completed in detail and signed by the Authorized Policyholder Representative.
- Part II** ♦ To be completed and signed by the injured person (if a MINOR under 18 years of age, this must be signed by a parent or legal guardian.)
- Part III** ♦ If filing for Disability Benefits, please have completed by the Authorized Policyholder Representative, injured person and attending physician.

PLEASE RETURN THIS COMPLETED FORM AND RELATED BILLS

Part I				THIS SECTION TO BE COMPLETED BY THE AUTHORIZED POLICYHOLDER REPRESENTATIVE			
Policyholder			Policy No.		Date of Injury		
Name of Injured Person		Occupation		Date Employed Full-Time		Social Security #	
Description of Injury (What, how, where, when and what part of body injured, i.e., broken leg, etc.)							
Describe Activity engaged in at time of injury (attach a police report if one was issued)							
Authorized Policyholder Representative (please print)			Signature		Telephone #		Date

Part II				THIS SECTION TO BE COMPLETED BY INJURED PERSON (PARENT OR GUARDIAN, IF MINOR)			
Address of Injured Person						Date of Birth	
Name and Address of Parent/Guardian (Street, State, and Zip Code)						Telephone #	
Have you previously had any treatment for this particular injury or any treatment to this area of your body? If "Yes", please describe the circumstances including how, when and where:						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you entitled to benefits under any other insurance policy covering this injury? If "Yes", please attach copies of statements of benefits paid or denied and complete the following:						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insurance Company				Plan #			
Name of person carrying other insurance coverage		Name of Employer providing other insurance coverage		Address			

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any physician, hospital, pharmacy, insurance company, Workers' Compensation carrier, Social Security office, Veterans Administration, retirement system, or other organization to release any information regarding the medical or mental health history, treatment, disability or benefits payable for this claim to Special Insurance Services, Inc., an authorized representative of Fidelity Security Life Insurance Company (FSL.) A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand that this authorization may be revoked at any time by providing written notice to Special Insurance Services, *except to the extent Special Insurance Services/FSL has taken action in reliance of this authorization, or to the extent that law allows Special Insurance Services/FSL to contest claims or coverage. Written notice must refer to Special Insurance Services and the authorization by indicating the date it was signed, and should be mailed to: Special Insurance Services, P.O. Box 250349, Plano, Texas 75025-0349.* By signing the below I certify the above information as true and CORRECT to the best of my knowledge.

Special Insurance Services/FSL may use this information to determine what, if any, benefit can be provided for any Fidelity Security Life coverage for which I may be eligible.

By State Law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, THE HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY ("AIDS".)

The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing and treatment records of alcohol and drug abuse.

Special Insurance Services/FSL may not condition treatment, payment, enrollment or eligibility on your completion of this authorization, except for the purposes of making eligibility, underwriting or risk determinations.

Special Insurance Services/FSL and its reinsurers agree to maintain the confidentiality of all the Insured's nonpublic financial or medical information given to us by any authorized entities listed above; *however, federal law (HIPAA) requires you to be advised information used or disclosed pursuant to this authorization may be subject to re-disclosure and is not longer protected by HIPAA rules.*

Signature (Injured Person or Parent/Guardian, if under 18) _____ Date _____

ASSIGNMENT OF BENEFITS

I also authorize Special Insurance Services/FSL to pay all bills in connection with the accident directly to the doctor, hospital, or other provider rendering service.

SIGNED _____ Date _____

My Employer is reimbursing my eligible expense. I hereby authorize payment directly to my Employer (copies of payment drafts must accompany claim.)

EMPLOYEE'S SIGNATURE _____ Date _____

Part III	EMPLOYER'S STATEMENT		
Current Weekly Salary (excluding overtime):		Average number of hours worked per week:	
Last day worked – was employee paid in full for this day? <input type="checkbox"/> Yes <input type="checkbox"/> No Has employee returned to full-time work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", date of return:	Have benefits been paid by Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please submit draft copies.		
What was employee's status at work when these expenses were incurred? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Disabled <input type="checkbox"/> Laid Off <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired <input type="checkbox"/> Other (explain):			
<i>In addition to the above information, please attach a complete 12 month salary/wage history, showing hours worked each week, gross pay for each week and hourly wage rate (three year history for commissioned employees).</i>			
Signature of Authorized Policyholder Representative			Date
INSURED'S STATEMENT			
Name and address of all physicians attending you for this condition:			
Date first treated by physician for this disability?		Did disability arise out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of your return to work: <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	Hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give name and address of Hospital and give dates confined:		
Are you entitled to benefits from any of the following for this disability? <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Salary Continuance <input type="checkbox"/> Social Security <input type="checkbox"/> Any Government Agency <input type="checkbox"/> Local, State or National Association or Social Disability Income Plan <input type="checkbox"/> Other (explain):			
I certify that the information given by me is support of this claim is true and CORRECT.		Insured's Signature	Date
ATTENDING PHYSICIAN'S STATEMENT			
Diagnosis and Concurrent Conditions (if diagnosis code other than IDCA, give name)			
Report of services: <i>Please attach a HCFA 1500 that completely details dates of services, place of services, procedure codes and charges.</i>			
Is condition due to an injury arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date accident happened	Date patient first consulted you for this condition
Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please specify when and describe:		Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is patient continuously and totally disabled (unable to work)? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", unable to work from: _____ to _____	
Patient was partially disabled from: _____ to _____		If still disabled, patient should be able to return to work:	
Patient was house confined from: _____ to _____			
Physician's Signature		Telephone #	Date
Physician's Name and Address		Individual Practitioners – Social Security #: _____	
		All Others – Federal Tax ID #: _____	
MUST BE FURNISHED UNDER AUTHORITY OF LAW			
SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENTS REQUIRED FOR CONTINUING PERIODS OF DISABILITY			

HOW TO FILE YOUR CLAIM

These instructions are being provided to you in order to help expedite your claim for medical and/or disability benefits. We would like your claim experience to go as smoothly as possible. Please help us to help you by following these instructions before submitting your claim. If you need help, please don't hesitate to call us.

MEDICAL

Fill in all spaces on the claim form. *Parts I and II are necessary for all medical claims.*

Part I:

- a) Be sure to include a *complete* description of your accident. Tell us exactly how the accident occurred. Example:
- Acceptable: "While moving boxes of vegetables, the contents shifted causing me to lose my balance. I fell on my right hand and broke my wrist."
- Unacceptable: "Moving boxes, broke my wrist."
- b) Make sure you fill in the *correct* Date of Injury.
- i) First medical charges *must be incurred within 30 days* of the Date of Injury.
- ii) Attach a copy of your time card or log sheet covering the Date of Injury, if available.
- c) *Part I must be signed by an Authorized Policyholder Representative.* This is usually someone who works in the benefits or personnel department of your Employer. Please check with your Employer. We have names on record, so you can contact us for this information, if necessary.

Part II:

- a) If you have ever had treatment for the same type of injury or to the same area of your body before, attach a list of all doctors who treated you in the past. Include their addresses and approximate dates of treatment.
- b) *If your coverage with us is secondary* and you have another insurance plan, you should file your claim with your other insurance company first. After they have processed your claim, send us a claim form, copies of all of your itemized bills, and copies of the other insurance company's payment explanations. We will then process our portion.
- c) Sign the Authorization to Use or Disclose Protected Health Information section so we may obtain any necessary additional information without delay.
- d) Sign the applicable payment authorizations:
- i) one gives us authorization to pay benefits directly to the places that treated you;
- ii) one gives us authorization to reimburse your Employer for any payments they may have already made to the places that treated you, or if you are disabled, payments they may have made to you for lost time. *Copies of your Employer's checks must be attached in order for us to reimburse them.*

DISABILITY

In addition to Parts I and II, *Part III is also necessary for all disability claims.* Follow the above instructions for Parts I and II, in addition to the following:

Part III:

- a) You must be declared totally and continuously disabled by a doctor *within 30 days of your accident.*
- b) The Employer's Statement should be filled out by the Authorized Policyholder Representative. There should be no blank spaces.
 - i) Weekly salary *must include regular salary only.* No overtime, commissions, or bonuses are to be included.
 - ii) *Part III must be signed by the Authorized Policyholder Representative who signed Part I.*
- c) You *must* complete and sign the Insured's Statement.
- d) Your doctor *must* complete and sign the Attending Physician's Statement.
 - i) If your doctor has a similar form of his own that he would rather provide, that is fine as long as it contains similar information;
 - ii) Be sure your doctor has filled in all the blanks properly, especially the dates of disability.
- e) When we receive first notice of your disability claim we will send you and your doctor information and forms explaining how to apply for additional disability benefits, in case you are disabled longer than the period noted on your initial claim form.

GENERAL INSTRUCTIONS

- a) Only one claim form is necessary per injury (except on-going disability claims.)
- b) *On-going disability claims will require medical updates and supplemental forms.*
- c) When you think you have everything in order, read through your claim form one more time. Make sure everything is filled in properly before sending it to us.
- d) *Keep* a copy of everything for your records.
- e) Mail your claim to Special Insurance Services:

Special Insurance Services, Inc.
P.O. Box 250349
Plano, Texas 75025-0349
- f) If assistance is needed, you can reach us at (972) 788-0699 or (800) 767-6811 between the hours of 8:00 a.m. and 5:00 p.m. (Central Standard Time), Monday through Friday.
- g) If you would like to leave us a message, please leave your name, social security number, and your specific question so we might have the proper information available when we return your call.