



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** ♦ To be completed by the parent or guardian.
- Part IV** ♦ To be completed by the 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		School Name (if applicable)	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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please describe the circumstances including how, when and where:			
Are you entitled to benefits under any other insurance policy covering this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please attach copies of statements of benefits paid or denied and complete the following:			
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 _____

Part III	THIS SECTION TO BE COMPLETED BY THE PARENT OR GUARDIAN	
Parent/Legal Guardian		SSN #
Employer	Address	
Health Insurance Carrier		Policy (Group) Number
If married, name of Spouse		SSN #
Spouse's Employer	Address	
Spouse's Health Insurance Carrier		Policy (Group) Number

PART IV	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		