

SISLink™ CLAIM FORM



FIDELITY SECURITY LIFE INSURANCE COMPANY

MAIL TO: **Special Insurance Services**
6509 Windcrest Drive, Suite 200
Plano, TX 75024
800-767-6811 • 972-788-0699

INSTRUCTIONS: PLEASE ANSWER ALL QUESTIONS FULLY

INSURED

1. Complete STATEMENT OF INSURED below, answering all questions fully.
2. Complete separate form for each family member.
3. **ATTACH EXPLANATION OF BENEFITS (EOB) provided by the insurer for your Comprehensive Major Medical Plan, if applicable, to this claim form.**
4. Attach copies of all medical bills. Bills must indicate date, place of service and diagnosis.
5. Return this claim form, all medical bills and EOBs to the address shown above.

STATEMENT OF INSURED

Your Name	<input type="checkbox"/> Male	Date of Birth	Policy Number	Social Security Number
	<input type="checkbox"/> Female			

Your Address (Number and Street)	City	State	Zip Code
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Name of Patient	Date of Birth	Relationship to Insured:
		<input type="checkbox"/> Self <input type="checkbox"/> Son
		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter

Describe Injury or Sickness Completely (<i>If injury, describe how accident occurred</i>)	Date of Injury or Beginning of Sickness
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Name of Physician Who First Treated This Condition	Date First Treated
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Address (Number and Street)	City	State	Zip Code
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Is Injury or Sickness Due to Employment?	Will You or Your Dependent File for Workers' Compensation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you or your dependent covered under any other insurance plan (including Blue Cross & Blue Shield), Student Accident, Hospital Indemnity or Government plan? Yes No

If "Yes", please specify insurance carrier's name, address, policy number and daily benefit amount, if applicable, for any other insurance plan that you currently have, or any plan that has terminated since the effective date of your coverage under SISLink.

Name of Company	Address	Coverage Type	Policy Number	Benefit Amount	Termination Date (if applicable)

See Reverse Side

IF CLAIM IS FOR DEPENDENT, COMPLETE THIS SECTION IN ADDITION TO STATEMENT OF INSURED

Dependent's Name	Relationship	Date of Birth
If child, is child married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any physician, hospital, pharmacy, insurance company, Worker's 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, 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 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 SYNDROME ("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 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 be advised information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected by HIPAA rules.*

Name of Patient/Claimant	Signature of Patient/Claimant	Date Signed
Social Security Number	Address	City, State and Zip Code

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

RETAIN A COPY FOR YOUR PERSONAL RECORDS

Send to:

Special Insurance Services

P.O. Box 250349

Plano, TX 75025-0349

Phone: 972-788-0699 FAX 972-960-0377

NOTE TO ALL PARTIES COMPLETING THIS FORM: 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.