**Life Benefits Worksite** | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
*American Fidelity Assurance Company* | 1-800-662-1113 | Fax: 800-818-3453 | AFA-Life-Claims@americanfidelity.com | **americanfidelity.com**

# Long-Term Illness Claim Form

## How to file a new notice of claim:

Please review your policy to review Rider benefits. Your Long-Term Illness Rider will pay benefits if you have a Long-Term Illness as defined in the Rider.

A Long-Term Illness means that the Insured has been certified within the last 12 months by a Licensed Health Practitioner as:

1. **permanently unable to perform, without Substantial Assistance from another individual, at least two out of five Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or**
2. **requiring Substantial Supervision due to permanent Severe Cognitive Impairment.**

The Activities of Daily Living are the basic human functions required for the Insured to remain independent. Activities of Daily Living are as follows: Continence, Dressing, Eating, Toileting, and Transferring. The definitions of each of these can be found below.

If you do not meet the definition of Long-Term Illness as described in your rider, no benefits will be payable.

After reviewing the benefits and eligibility requirements of the rider, please complete and return the claim form below if appropriate.

## Rider Definitions

**Continence:** The ability to maintain control of bowel and/or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag) without Standby or Hands-On Assistance from another person. An Insured is considered continent if unable to control bowel or bladder function but is able to maintain a reasonable level of personal hygiene using ostomy supplies or other devices such as diapers, protective undergarments, or catheters.

**Dressing:** Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs without Standby or Hands-On Assistance from another person. An Insured is able to dress if the only assistance required is modified fasteners, zippers, or snaps.

**Eating:** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) after it has been prepared for the Insured or by a feeding tube or intravenously without Standby or Hands-On Assistance from another person. An Insured is able to eat if the only assistance required is adaptive utensils.

**Toileting:** Getting to and from the toilet, getting on and off the toilet, and performing associated hygiene without Standby or Hands-On Assistance from another person. An Insured is able to toilet if using a commode, urinal, or bedpan and able to empty and clean it.

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## Rider Definitions (continued)

**Transferring:** Moving into or out of a bed, chair, or wheelchair without Standby or Hands-On Assistance from another person. An Insured is able to transfer if able to do so by use of equipment such as canes, quad canes, crutches, grab bars, other support devices, mechanical or motorized devices.

**Severe Cognitive Impairment:** A permanent deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in:

1. short- or long-term memory;
2. orientation to people, places, or time; and
3. deductive or abstract reasoning.

A Severe Cognitive Impairment includes Alzheimer's disease and similar forms of irreversible dementia.

**Substantial Assistance:** Hands-On Assistance or Standby Assistance.

1. **Hands-On Assistance** means the physical assistance of another person without which the Insured would be unable to perform the Activities of Daily Living.
2. **Standby Assistance** means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while they are performing the Activities of Daily Living.

**Substantial Supervision:** Continual supervision by another person is necessary to protect the Insured from threats to his or her health or safety. Such supervision may include cueing by verbal prompting, gestures, or other demonstrations.

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## STATEMENT OF INSURED To be completed by claimant or legal representative.

| Insured's Full Name: (last, first, middle initial) | |
|---|---|
| Social Security Number: - - | Date of Birth: / / |
| Phone Number: | Policy Number: |
| Address (P.O. box or street, city, state & zip): | |
| Name of Power of Attorney (if applicable): | Phone Number: |
| Address: | |
| Describe sickness or injury: | |
| If injury, how and when did it happen: | |
| If sickness, date symptoms were first noticed: / / | |
| Date of first treatment: / / | Date of diagnosis: / / |
| Name of Physician first consulted for the injury or sickness: | |
| Physician's Address: | |
| Name of Attending Physician (if different from above): | |
| Attending Physician's Address (if different from above): | |

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## TYPE OF CARE

Please indicate level of care currently being received by the claimant.

| Facility-Based Care | Home/Community-Based Care |
|---|---|
| ❒ Nursing Home Facility<br>❒ Assisted Living Facility<br>❒ Hospice Facility<br>❒ Other (Specify) ___________________________ | ❒ Home Health Care<br>❒ Homemaker Services<br>❒ Adult Day Care<br>❒ Other (Specify) ___________________________ |
| Name of Facility or Service Provider/Center: | Phone Number: |
| Address (P.O. box or street, city, state & zip): | |
| Treatment/Care/Services Provided: | Dates of Confinement or Service<br>Start: / /<br>End: / / |
| Name of Additional Facility or Service Provider (if applicable): | Phone Number: |
| Address (P.O. box or street, city, state & zip): | |
| Treatment/Care/Services Provided: | Dates of Confinement or Service<br>Start: / /<br>End: / / |
| Name of Additional Facility or Service Provider (if applicable): | Phone Number: |
| Address (P.O. box or street, city, state & zip): | |
| Treatment/Care/Services Provided: | Dates of Confinement or Service<br>Start: / /<br>End: / / |

Name of Person Completing Form: ____________________________________________________ ___________________________
(Must be Insured or Power of Attorney) Telephone

Relationship to Insured:____________________________________________________________________________________

My signature below indicates that I understand that the claims processing procedure includes the collection of personal medical information. I understand that completion of this Application for Benefits form, applicable Claim Form(s) and any other form(s) required by the Insurance Company or its designee(s) is not a guarantee of payment of benefits. I attest that all of the information on this Application for Benefits form is true and complete, to the best of my knowledge and belief. I understand that the Insurance Company reserves the right to require due Proof of Loss.

_________________________________________________________ ________________________
Signature Date

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# AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

The purpose of this form is to allow American Fidelity Assurance Company (AF), or business partners acting on behalf of AF in the administration of AF products and services to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, AF may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my Customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing AF who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities or their business associates; c) health plans; d) Veteran's Administration; e) past or present employers; f ) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. AF will only disclose any data collected pursuant to this authorization as necessary for our legitimate business purposes, and only to the extent allowed by law.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated.

I understand that AF may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or an inability to pay benefits under my policy if my failure to sign results in AF not having enough information to process my benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AF has taken action in reliance on the authorization; or, the law provides AF with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations. In addition to the types of information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of any relevant claim for benefits, whichever occurs first.

AF Account# ______________ Printed Name of Patient ______________ Patient's Date of Birth ______________

Signature (Patient) or Personal Representative (if applicable) ______________ Date Signed ______________

Relationship of Personal Representative to Patient (if applicable) ______________

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

**Please retain a copy for your personal records, or you may request a copy from our Company.**

AMERICAN FIDELITY
a different opinion

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# Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

**If you live in a jurisdiction not mentioned below, the following applies to you:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

**Alabama** - 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.

**Alaska** - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona** - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia** - 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.

**California and Texas** - For your protection California and Texas law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado** - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware, Idaho and Oklahoma** - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Florida** - Any person who knowingly and with intent to injure, 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.

**Indiana** - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Kentucky** - Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Maine, Tennessee, Virginia and Washington** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland** - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota** - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire** - Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey** - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico** - 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 CIVIL FINES AND CRIMINAL PENALTIES.

**Ohio** - 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 is guilty of insurance fraud.

**Pennsylvania** - 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.

**Puerto Rico** - Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.