

HOSPITAL CONFINEMENT INDEMNITY (GAP) CLAIM FORM



FIDELITY SECURITY LIFE INSURANCE COMPANY

MAIL TO:

Assurant Employee Benefits (Home Office)
PO Box 419568 Kansas City Missouri 64141-6568
Fax 816.474.2320

CHECKLIST

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. Bill must indicate date, type and place of service and diagnosis.**
5. Return this claim form, all itemized bills and EOBs to the address shown above or fax to the above number.

STATEMENT OF INSURED

Your Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Policy Number	Social Security Number		
Your Address (Number and Street)		City	State Zip Code
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:			
Is Injury or Sickness Due to Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Will You or Your Dependent File for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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 is guilty of insurance fraud.

***** NOTICE – See State Specific Fraud Notices, Pages 3 And 4 *****

I certify that the information given by me in support of this claim is true and correct.



Insured's Signature

Date

IMPORTANT! PLEASE COMPLETE THE AUTHORIZATIONS INCLUDED WITH THIS FORM.

Assurant Employee Benefits is the brand name for Group Hospital Confinement Indemnity insurance underwritten by Fidelity Security Life Insurance Company and administered by Union Security Insurance Company.

Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568
T 800.451.4531 • F 816.474.2320
KCBenefitCenter@assurant.com



P.O. BOX 418131 • 3130 BROADWAY • KANSAS CITY, MO 64141-8131
800-648-8624 (ALL AREAS) • FAX 816-968-0560

This authorization complies with the HIPAA Privacy Rule.

Name of proposed insured/patient (please type or print)

____/____/____
Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (“My Providers”) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Union Security Insurance Company or Fidelity Security Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Union Security Insurance Company or Fidelity Security Life Insurance Company may: 1) underwrite my applications 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 I have or have applied for with Fidelity Security Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64111-8131, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that Fidelity Security Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Fidelity Security Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that my authorized representative or I have received a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative

Date

Address

Description of Personal Representative’s Authority or Relationship to Proposed Insured/Patient

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Claimant's signature _____ Date _____

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:

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.

If you live in the states of Arizona or New Jersey, the following statement applies to you:

A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana, Maryland or Rhode Island, the following statement applies to you:

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.

If you live in the state California, the following statement applies to you:

Any person who knowingly presents a 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.

If you live in Colorado, the following statement applies to you:

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you:

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia, the following statement applies to you:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

If you live in New Hampshire, the following statement applies to you:

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.

If you live in New York the following statement applies to you:

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 act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

If you live in Minnesota, the following statement applies to you:

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

If you live in Texas, the following statement applies to you:

Any person who knowingly presents a 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.

If you live in a state other than mentioned above, the following statement applies to you:

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.