Amalgamated Life
Life • Accident • Disability

Amalgamated Life Insurance Company
Voluntary Benefits Department
P.O. Box 5453, White Plains, NY 10602-5453
Toll-Free: 1-866-975-4089
Fax: 1-914-367-4114

Voluntary Benefits – ACCIDENT INSURANCE
Accident Claim Form

This form is for filing a claim under the ACCIDENT INSURANCE POLICY only. Review your policy for the specific benefits covered. Failure to complete all sections or to provide requested documentation may result in a delay in processing this claim.

Policyholder/Claimant Information

Policy Number:	Policyholder/Insured Name: (First) (Middle) (Last)				Social Security Number:
Claimant/Patient Name: (First) (Middle) (Last)		Relationship to Insured: Self [ ] Spouse[ ] Child [ ]	Gender: Male [ ] Female [ ]	Age:	Date of Birth (mm/dd/yy)
Policyholder Home Address: (Street) (Apt)		(City)	(State)		(Zip)
Home Telephone Number: Cell Telephone Number:	Email Address:	Have you moved since your policy application? Yes [ ] No [ ] If yes, is above your new address? Yes [ ] No [ ]			

Check off the box for the benefit(s) being claimed

Section One
(Refer to SECTION ONE Instructions Below)

[ ] Catastrophic Accident (Loss of Limb/Eye)
[ ] Burns
[ ] Concussion
[ ] Dislocation of Joint
[ ] Eye Injury
[ ] Fracture of Bone
[ ] Laceration
[ ] Ruptured Disc
[ ] Torn Knee Cartilage

Section Two
(Refer to SECTION TWO Instructions Below)

[ ] Accident Follow up Visit
[ ] Air Ambulance
[ ] Ambulance
[ ] Blood, Plasma, Platelets
[ ] Emergency Dental Work
[ ] Emergency Room Treatment
[ ] Hospital Admission
[ ] Hospital Confinement/Day
[ ] Hospital ICU Admission
[ ] Hospital ICU Admission/Day
[ ] Initial Office Visit
[ ] Major Diagnostic Exam
[ ] Medical Appliances
[ ] Pain Management/Epidural
[ ] Physical Therapy per day
[ ] Prosthetic Device/Artificial Limb
[ ] Rehabilitation Unit per Day
[ ] X-Rays

Section Three
(Refer to SECTION THREE Instructions Below)

[ ]Transportation
[ ] Lodging

Describe below the benefit(s) you are claiming:

INSTRUCTIONS

SECTION ONE: Complete the Claim Information Section below and have your physician complete the Attending Physician's Statement. Submit proof of the type of injury claimed. This can be a surgery bill, an operative report, or other documentation that proves/describes the type of injury.

SECTION TWO: Complete the Claim Information Section below and submit a detailed itemized bill(s) from the provider of service that includes patient name, DOS, provider name & address, dates of service, charges, etc. You may also submit an Explanation of Benefits (EOB) from your insurance carrier that shows the details of the service (s) rendered. The attending physician statement may be required.

SECTION THREE: Complete the Claim information Section below, and answer the following questions. Submit proof of travel expense and/or lodging expense. The Attending Physician's statement may be required.

Answer the following questions, if applicable

Type of personal vehicle used:	Mileage:	Expense:

Reason for vehicle use:

Driving Location FROM/TO:

Name of Lodging:	FROM/TO:	Expense:

Reason for Lodging:

Indicate names and relationships of those who accompanied you:

Claim Information Section

Date of Accident:	Time of Accident:	Location of Accident:

Provide details of Accident:

Were you hospitalized? YES [ ] NO [ ] If yes, provide dates and name of facility:

Include a copy of the hospital bill with this claim, if available, or any other supporting documents.

Was the accident related to a motor vehicle accident or other accident investigated by any law enforcement agency? YES [ ] NO [ ]
Describe what occurred:

Name of Agency:

Note: If the injury was a result of an automobile accident or other accident investigated by any law enforcement agency, you must provide the police report.

CLAIMANT CERTIFICATION

I HEREBY CLAIM THE BENEFIT INDICATED ABOVE AND CERTIFY THAT FOR THE PERIOD COVERED BY THE CLAIM, THAT THE INFORMATION PROVIDED AND THAT THE FOREGOING STATEMENTS, INCLUDING ANY ACCOMPANYING STATEMENTS, ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.

FRAUD WARNING: For residents of all other states, please see page 5 of this form

Fraud Certification: 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. For residents in the following states, please see the last page of this form. Alaska, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, New Jersey, New Mexico, Oregon, Pennsylvania, Tennessee, Texas and Virginia.

New York Residents: 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 or misleading, information concerning any fact material thereto, commits a fraudulent insurance 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.

Claimant Name (Print): _____

Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE INFORMATION

Authorization to Release information: Read, sign and date the Authorization for Release of Health Care Information Pursuant to HIPAA on page three (3), and provide a copy to your treating physician. Submit a copy to Amalgamated Life along with your claim.

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Voluntary Benefits - Accident Insurance

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:_____ Social Security No. _____

Address: _____ Date of Birth: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Article 27-F of the New York State Public Health Law, and 42 U.S.C. 290dd-2 and its implementing regulations at 42 C.F.R. Part 2, I understand the following:

I hereby give permission and authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; and employer that has information about my health, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer and evaluate claims for Amalgamated Life Insurance Co, including Alicare Medical Management (AMM), an affiliate of Amalgamated Life Insurance Co.

This authorization may include disclosure of information relating to: Alcohol and Drug Abuse, Mental Health Treatment, except psychotherapy notes, and Confidential HIV Related Information, only if I place my initials on the appropriate item below. In the event the health information described below includes any of these types of information, and I initial the line on the box in the item below, I specifically authorize release of such information to Amalgamated Life Insurance Co., including Alicare Medical Management (AMM), an affiliate of Amalgamated Life Insurance Co.

IMPORTANT – Please complete the check boxes below even if the categories should not necessarily apply to the patient's medical records.

☐ Do ☐ **Do Not** want information about Mental Health released _____ (initial)
☐ Do ☐ **Do Not** want information about HIV Tests & Related Information released _____ (initial)
☐ Do ☐ **Do Not** want information about Alcohol and/or Substance Abuse released _____ (initial)

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of the release or disclose of HIV-related information, I may contact the New York State Division of Human Rights at (212) 961-8650 or the New York City Commission of Human Rights at (212) 308-7450. These agencies are responsible for protecting rights of New York State residents.

I understand that any information Amalgamated Life or AMM obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for disability benefits, which may include assisting me in returning to work. I further understand that authorized recipients to my medical information may, in certain instances, have the right to redisclose my medical documentation without the need to obtain additional written consent from me. I understand that such redisclosures may no longer be protected by federal or state law.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, if I do not authorize release of my medical information, this may result in Amalgamated Life not being able to process my claim.

I have the right to revoke this Authorization at any time by providing written notice of revocation to Amalgamated Life Insurance Co. I am aware that my revocation will not be effective until received by Amalgamated Life, and will not be effective regarding the uses and/or disclosures of my "Information" that has been made prior to receipt of my revocation. This authorization is valid for one year from the date below or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

This authorization does not authorize my medical provider to discuss my health information or medical case with anyone other than Amalgamated Life Insurance Co. or AMM.

➢

_____ _____

Patient's Signature or representative authorized by law **DATE**

If other than patient: I signed on behalf of the patient as _____ (relationship).
If Power of Attorney Designee, Guardian, Conservator, please attach a copy of document granting authority.

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Voluntary Benefits – ACCIDENT INSURANCE
Accident Claim Form
Attending Physician's Statement

Policyholder/Claimant Information

Policy Number:	Policyholder/Insured Name: (First) (Middle) (Last)	Social Security Number:

Claimant/patient Name: (First) (Middle) (Last)	Relationship to Insured: Self [ ] Spouse [ ] Child [ ]	Gender: Male [ ] Female [ ]	Age:	Date of Birth (mm/dd/yy)
Home Address:				

Physician Section

Date of Injury:	Type of Injury:
Dates of Treatment for this injury:	
Describe the type of treatment you provided for this injury:	
Diagnosis Description (include all related diagnoses):	Diagnosis Code(s):
If patient was hospitalized, date of confinements and reasons:	If Patient had surgery, date and type of surgery:
Indicate the type of injury from the list in Section One of Accident Claim Form (page 1) that the patient has incurred and provide specific details:	

FRAUD WARNING: For all other states, please see page 5 of this form

Fraud Certification: 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. For residents in the following states, please see the last page of this form. Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, New Jersey, New Mexico, Oregon, Pennsylvania, Tennessee, Texas and Virginia

New York Residents: 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 or misleading, information concerning any fact material thereto, commits a fraudulent insurance 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.

Physician Certification and Signature

Physician name (print) _____ **Degree/Specialty:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip**:_____

Telephone No. (____)_____ **Fax No**. (____)_____ **EIN:** _____

Signature: _____ **Date:** _____

FRAUD WARNINGS FOR CLAIM FORMS

Alabama, Arkansas, Louisiana, Massachusetts, New Mexico and West Virginia Residents: 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 restitution, fines and confinement in prison, or any combination thereof.

Maine, Tennessee, Virginia and Washington Residents: 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.

Delaware, Idaho and Indiana Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Alaska Residents: 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 the law.

Arizona Residents: 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.

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

Colorado Residents: 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.

District of Columbia Residents: 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.

Florida Residents: 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.

Kentucky Residents: 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.

Maryland Residents: 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 Residents: 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 Residents: Any person who, with a purpose to injure 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 N.H. Rev. Stat. Ann. §638.20.

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

Ohio Residents: 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.

Oklahoma Residents: 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.

Oregon Residents: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement 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.

Texas Residents: 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.