



## GROUP ACCIDENT INSURANCE

Underwritten by: National Guardian Life Insurance Company  
Administered by: AlwaysCare Benefits, Inc.

### Claim Filing Instructions

We understand an illness or injury creates emotional, physical and financial challenges, and you have our commitment to provide you with responsive service and to be understanding and sensitive to your circumstances during the claim process.

The information provided on this claim form will be used to evaluate your eligibility for Accident benefits. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Please enclose any additional information you feel will assist us in the evaluation of your claim.

#### INSTRUCTIONS:

- To avoid delays in processing, please completely fill out the section which applies to your specific claim.
- Include your group number. To obtain your group number, you may call 1-888-729-5433, Ext. 2013.
- For **all claims** submitted, please complete **Sections A, B and C and the Authorization for Release of Information.**
- For claims regarding an Emergency Room visit, complete sections A through C.
- For claims regarding Hospitalization, complete sections A through D.
- For claims regarding Transportation and Lodging, complete sections A through E.
- Accidental Death claims will not be paid until a death certificate is provided.
- Please find your state's Fraud Statement and sign where indicated.
- Additional claim forms are available on our website at [www.AlwaysCareBenefits.com](http://www.AlwaysCareBenefits.com).
- Please remember that no benefits are paid for accidents incurred during the service waiting period as defined in the certificate.

#### SUBMIT CLAIMS TO:

**By Mail:** AlwaysCare Benefits, Inc.  
c/o Accident Claims  
P.O. Box 98100  
Baton Rouge, LA 70898-9100

**By Fax:** 1-888-843-5872

**By Email:** [AccidentClaims@AlwaysCareBenefits.com](mailto:AccidentClaims@AlwaysCareBenefits.com)

**If you have any question about completing this form, please call: 1-888-729-5433, Ext. 2013**

The furnishing of this form or its acceptance by the Company as proof must not be construed as an admission of any liability on the part of the Company, nor as a waiver of any of the conditions of the insurance contract. If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact Customer Service at 1-888-729-5433, Ext. 2013.



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**NOTICE OF CLAIM FOR  
GROUP ACCIDENT INSURANCE**

**SECTION A – Employer’s Statement: (To be completed by the employer)**  
*To ensure your privacy, please have the Employer section of the claim form completed first.*

<b>EMPLOYER INFORMATION:</b>		
<b>Employer Name:</b>	<b>Employer Address</b> (including city, state and zip):	
<b>Group Code:</b>	<b>Telephone Number:</b>	<b>Fax Number:</b>
<b>Name &amp; address of location where employee works</b> (if different from above):		<b>Email Address:</b>
<b>Does the employee contribute to the cost of their Accident Insurance premium?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If “yes”, please complete the following: ____% Paid by employer ____% Paid by employee (PreTax <input type="checkbox"/> Post Tax <input type="checkbox"/>		

<b>EMPLOYEE INFORMATION:</b>		
<b>Employee’s Name:</b>	<b>Date of Birth:</b>	<b>Social Security Number:</b>
<b>Occupation:</b>	<b>Date of Hire:</b>	Full time <input type="checkbox"/> Part time <input type="checkbox"/> If part time: Hours worked per week: ____
<b>Employee coverage effective date:</b>	<b>Dependent coverage effective date:</b> Spouse: _____ Child(ren): _____	
<b>Was employee actively at work at the time of enrollment:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Has the employee returned to work:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what date: _____		
<b>Was the employee actively at work at time of the accident:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Date employment terminated</b> (if applicable):		
<b>Remarks:</b>		

**FRAUD NOTICE:** *I have read and understand the fraud statement applicable to my state on pages 8-9 of this claim form.*

By signing this form I certify that all information stated above is true.

Printed Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Signature and Title: \_\_\_\_\_ Date: \_\_\_\_\_



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**NOTICE OF CLAIM FOR  
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**SECTION B – Claimant Statement:**

(To be completed by claimant. If claimant is a minor, a parent or legal guardian must complete.)

<b>Claimant:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<b>Type of Claim:</b> <input type="checkbox"/> Accident/Injury <input type="checkbox"/> Emergency Room (E/R) Visit <input type="checkbox"/> Hospitalization/Intensive Care <input type="checkbox"/> Transportation/Lodging <input type="checkbox"/> Accidental Death or Dismemberment	
<b>EMPLOYEE INFORMATION (complete all information):</b>			
<b>Employer Name:</b>		<b>Employer Address</b> (including city, state and zip):	
<b>Group Code:</b>	<b>Occupation</b>	<b>Essential Job Duties:</b>	
<b>Employee Name:</b>	<b>Date of Birth:</b>	<b>Social Security Number:</b>	<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>	<b>Fax Number:</b>
<b>Employee Mailing Address</b> (including city, state and zip):		<b>Email Address:</b>	
<b>CLAIMANT INFORMATION (if different from employee):</b>			
<b>Claimant Name:</b>		<b>Date of Birth:</b>	<b>Social Security Number:</b>
<b>Mailing address</b> (including city, state and zip):		<b>Marital Status:</b>	<b>If dependent child*:</b> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____ <small>* If dependent child is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.</small>
		<b>Gender:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>	
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>	<b>Email Address:</b>
<b>COMPLETE FOR ALL ACCIDENT CLAIMS:</b>			
<b>Date of Accident:</b>	<b>Time of Accident:</b> _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<b>Was the claimant working at the time of the accident:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Please explain how the accident happened.</b> (If you need more space, please attach a separate sheet of paper).			

**FRAUD NOTICE:** I have read and understand the fraud statement applicable to my state on pages 8-9 of this claim form.

**Please Print Name:** \_\_\_\_\_

**Signature of Claimant (or authorized person):** \_\_\_\_\_ **Date signed:** \_\_\_\_\_

I signed on behalf of the claimant, as \_\_\_\_\_ (indicate relationship). If authorized Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.

Please attach itemized copies of any bills related to this accident including doctor, emergency room, hospital, ambulance, death certificate and motor vehicle incident/accident report. Please ask your physician to complete the Attending Physician Statement included in this package.



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**SECTION C – Attending Physician Statement:**  
 (To be completed and signed by the physician)

<b>Claimant Name:</b>	<b>Date of Birth:</b>	<b>Social Security Number:</b>
<b>Name of Physician:</b>	<b>Phone number:</b>	
<b>Address</b> (including city, state and zip):	<b>Fax Number:</b>	
	<b>Email address:</b>	
<b>Name of Hospital:</b>	<b>Phone number:</b>	
<b>Date of office visit related to this accident:</b>	<b>CPT Code(s):</b>	
<b>Diagnosis ICD-9 Codes(s):</b>		
<b>Is condition the result of an accidental injury?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Acute <input type="checkbox"/> Re-injury <input type="checkbox"/>		
<b>If acute, please provide date and description:</b>		
<b>If re-injury, please provide date(s) of prior injuries and description(s):</b>		
<b>If related to fracture or dislocation, please indicate:</b> Closed <input type="checkbox"/> Open <input type="checkbox"/> Unknown <input type="checkbox"/>		
<b>Name of bone(s) fractured:</b>		
<b>If related to a laceration, please indicate the length:</b>		
<b>If related to a burn, please indicate the degree:</b> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> (percent of body burned _____ %) 3 <sup>rd</sup> <input type="checkbox"/> (square inches of body surface burned _____)		
<b>Are you related to this patient?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is the relationship: _____		

**FRAUD NOTICE:** I have read and understand the fraud statement applicable to my state on pages 8-9 of this claim form.

**Signature of physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**SECTION D – Hospitalization / Intensive Care Claims:**  
 (To be completed and signed by the physician)

<b>Claimant Name:</b>		<b>Date of Birth:</b>	<b>Social Security Number:</b>
<b>Diagnosis:</b>		<b>ICD-9 CODE:</b>	
<b>Date of Inpatient Hospital Confinement:</b> Admit date: _____ Discharge date: _____		<b>Date of Confinement in Intensive Care</b> (including Coronary Care Unit): Admit date: _____ Discharge date: _____	
<b>Hospital Name:</b>		<b>Telephone:</b>	
<b>Hospital Address</b> (including city, state and zip):			
<b>Physician's Name:</b>		<b>Medical Specialty:</b>	
<b>Address</b> (including city, state and zip):		<b>Telephone Number:</b>	
<b>Are you related to this patient?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is the relationship: _____			
<b>Procedure Performed:</b>			<b>CPT Code:</b>

**FRAUD NOTICE:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**SECTION E – Transportation / Lodging Claims:**

(To be completed by claimant. If claimant is a minor, a parent or legal guardian must complete.)

*Transportation and Lodging must exceed 100 miles from the claimant's primary residence.*

<b>Claimant Name:</b>		<b>Date of Birth:</b>	<b>Social Security Number:</b>
<b>Type of Transportation</b> (Please indicate the mode of transportation. If personal vehicle was use, provide a detailed travel log of miles traveled):			
<b>FACILITY:</b>			
<b>Date of admission/visit:</b>		<b>Date of discharge:</b>	
<b>Facility Name:</b>		<b>Phone number:</b>	
<b>Mailing Address</b> (including city, state and zip):		<b>Fax number:</b>	
<b>Facility type (i.e. hospital, clinic, rehabilitation center etc):</b>			
<b>Treating physician name:</b>		<b>Specialty:</b>	
<b>Mailing address</b> (including city, state, & zip):		<b>Office phone number:</b>	
		<b>Office fax number:</b>	
<b>LODGING:</b>			
<b>Hotel Name:</b>		<b>Phone number:</b>	
<b>Mailing address</b> (including city, state, & zip):		<b>Fax number:</b>	
<b>Check in date:</b>		<b>Check out date:</b>	

**Please Print Name:** \_\_\_\_\_

**Signature of Claimant (or Authorized Person):** \_\_\_\_\_ **Date signed:** \_\_\_\_\_

I signed on behalf of the claimant, as \_\_\_\_\_ (indicate relationship). If authorized Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.

**Attach original receipts for eligible transportation and lodging (room & tax only) expenses.**



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**Authorization to Release Information**

<b>Name of Patient:</b>	<b>Patient's Date of Birth:</b>
<b>Patient's Address:</b>	<b>Patient's Social Security Number:</b>

I **authorize** any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the injured or deceased's occupation, finances and health including protected health information, individually identifiable health information, summary health information, mental health, **HIV/AIDS\***, and alcohol/drug records to release all such records in their entirety *excluding psychotherapy notes* to AlwaysCare Benefits, Inc., and its representatives (collectively and severally, the "Company").

I understand that the Company will use the information obtained by this authorization for the purposes of evaluating and administering claims for benefits or as may be lawfully required or permitted, or as I may further authorize.

I understand that I may receive a copy of this authorization, and that this authorization is valid for two years or as limited by state requirements, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand revocation or failure to sign this authorization may impair the ability of AlwaysCare Benefits, Inc., and its representatives to evaluate my claim and, as a result, may be a basis for denying my claim.

A photographic or electronic copy of this authorization is as valid as the original.

I understand that information disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal or state rules governing privacy and confidentiality of health information.

<b>Name of person signing this form:</b>	<b>Telephone Number:</b>
<b>Mailing Address</b> (including city, state and zip):	

In what capacity are you signing this form? (Note: if other than the Employee/Patient or Surviving Spouse of the Employee/Patient for whom information is to be released, please attach appropriate documentation substantiating your authority.)

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\* If you reside in **California**: This authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

\* If you reside in **Connecticut, Maine or Massachusetts**: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). Separate authorizations signed by the insured claimant, or employee-claimant (for self insured business) are required each time results are released.

\* If you reside in **Vermont**: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING AlwaysCare Benefits, Inc., or its representatives to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and AlwaysCare Benefits, Inc., and its representatives shall comply, as applicable, with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.



## FRAUD STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below.

**For residents of all states EXCEPT Arizona, Arkansas, California, Colorado, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, New York, Tennessee, Virginia, Washington and the District of Columbia:**

*"Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud."* AlwaysCare Benefits, Inc. shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

**For residents of 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."

**For residents of Arkansas:**

"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 OF CALIFORNIA:**

**"FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "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."**

**For residents of Colorado:**

**"It is unlawful to knowingly provide false, incomplete, or misleading 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 an settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies."**

**For residents of the District of Columbia:**

**"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 were provided by the applicant."**

**For residents of 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."

**For residents of Kansas:**

"Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of committing a fraudulent insurance act."

**For residents of Kentucky:**

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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."

**For residents of Louisiana:**

"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 of Maine:**

"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."

**For residents of Maryland:**

**"ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAYBE SUBJECT TO FINES AND CONFINEMENT IN PRISON."**

**For residents of 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."



## **FRAUD STATEMENTS CONTINUED:**

### **For residents of New Jersey:**

"Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

### **For residents of 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."

### **For residents of New York:**

"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 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."

### **For residents of 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,."

### **For residents of 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"

### **For residents of 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 a person to criminal and civil penalties."

### **For residents of Puerto Rico:**

"Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

### **For residents of Rhode Island:**

"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 of Tennessee:**

"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage."

### **For residents of Virginia:**

"Any person who, with the 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 have violated state law."

### **For residents of Washington:**

"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage."