Bankers Fidelity™

Mail To: **Bankers Fidelity Life Insurance Company**
P. 0. Box 105652, Atlanta, Georgia 30348-5652
Toll Free Claim Number: 1-866-458-7499, 8:00 A.M. to 5:30 P.M. (EST)
www.bflic.com

CLAIM FORM

Has a Claim been filed before for this loss? ..... ❒ Yes ❒ No

Policyholder Name *(First, Middle & Last)*		Policy Number	Date of Birth
Street Address ❒ *Check here if new address*		Home Phone Number ( )	Work Phone Number & Ext. ( )
(City, State & Zip Code)		Social Security Number	Male ❒ Female ❒
Patient *(First, Middle & Last)*	Age	Patient's Social Security Number	Date of Birth

Patient is your: ❒ Self ❒ Spouse ❒ Son ❒ Daughter If patient is your child, is he/she full-time student? ❒ Yes ❒ No

This Claim is for: ❒ Accident ❒ Disability ❒ Critical Illness ❒ Wellness ❒ Medicare Supplement
❒ Hospital Indemnity ❒ Cancer (If claim is being filed for cancer, enclose pathology report) ❒ Other _____

What sickness or injury are you claiming? _____

List all doctors who have treated you for this condition: Name/Address _____

_____ Phone Number _____

Have you received treatment, medication or advice from a doctor in the past for this or a similar condition? ..... ❒ Yes ❒ No

If "Yes," give date, name and address of physician: _____

_____

If you were hospitalized: Date admitted _____ Date Discharged _____

Name of Hospital _____ Address _____

ACCIDENTAL INJURY: (Attach copy of police report if auto accident.)

(A) Date of injury _____ (B) Where did it happen? _____ (C) Time of accident _____ ❒ A.M. ❒ P.M.

(D) Tell us exactly how your accident happened _____

_____ (E) ❒ On the job ❒ Off job

(If on the job attach Workers' Comp report of injury)

(F) Did your injuries occur while you were working for pay or profit? ✎ ❒ Yes ❒ No (G) Monthly Income _____

Date first sought treatment _____

Dates unable to work _____ ❒ A. M. ❒ P. M. to _____ ❒ A. M. ❒ P. M.

Dates confined to your home _____ ❒ A. M. ❒ P. M. to _____ ❒ A. M. ❒ P. M.

Have you returned to your main (or principal) duties? ..... ❒ Yes ❒ No

Date returned part-time _____ Date returned full-time _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Authorization To Release Information

I hereby authorize any physicians, practitioners, hospitals, clinics, pharmacists, insurance companies, employers, credit reporting agencies, government agencies and other persons or institutions to furnish Bankers Fidelity Life Insurance Company or its authorized representative copies of any and all information, data or records you have regarding any illness or injury, physical or mental condition, medical history, consultation, prescriptions, treatment, or employment pertaining to me. I understand that I have a right to request a copy of this authorization. A photocopy of this authorization shall be considered effective and valid as the original.

Dated: _____ Signed:X _____
Insured or Beneficiary

If you are claiming disability benefits the reverse side of this form must be completed by both your employer and attending physician.

EMPLOYER'S STATEMENT

Employee's Name	Date of Hire	Date Employee Was Last Actively At Work *(Complete on every claim)*
Total Disability: Between What Dates Did Employee Give Up all Duties? From _____ (Month Day Year) To _____ (Month Day Year)		Why Did Employee Cease Work? ❒ Injury ❒ Dismissed ❒ Vacation ❒ Temporary Layoff ❒ Quit ❒ Leave of Absense
Partial Disability: Between What Dates Did Employee Perform Only Part Of Duties? From _____ (Month Day Year) To _____ (Month Day Year)		
Date Returned To Work *(Month, Day & Year)* Workers' Comp. Claim Filed For This Disability? ..... *❒ Yes ❒ No *Attach 1st Report of Injury.		Has Employment Terminated? ❒ Yes ❒ No If Yes, Date Terminated _____
Employer	Authorized Signature	Date
Address	Print Name	
Phone ( )	Title	

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Address / City / State / Zip Code	Age

1. Nature and origin of injury _____

   Diagnosis (Describe complications, if any) Confirmed by X-Ray? ❒ Yes ❒ No ICD -10: _____
2. When did symptoms first appear or accident happen? Date *(Month, Day & Year)* _____
3. When did patient first consult you for this condition? Date *(Month, Day & Year)* _____
4. How did conditions originate? _____
5. Has patient ever had same or similar condition? ..... ❒ Yes ❒ No
   (If "Yes," state when and describe) _____
6. Describe any other disease or infirmity affecting present condition. _____
7. Nature of Surgical or Obstetrical procedure, if any.
   Dates _____ ❒ Closed Reduction ❒ Open Reduction ❒ Metal Fixation
   Description _____ Procedure Code _____
8. Give dates of treatment, and nature of treatment other than surgical. _____ Dates
   ❒ Office ❒ Home ❒ Hospital Nature of Treatments _____
9. Is patient still under your care for this condition? ❒ Yes ❒ No If discharged, give date _____
10. If patient hospitalized, give: Dates of Confinement: From _____ To _____
    Name and address of hospital _____
11. How long was or will patient be continuously totally disabled (unable to work)? From _____ To _____
12. Is total disability expected to be permanent? ❒ Yes ❒ No Expected date to return to work _____
13. How long was or will patient be partially disabled? From _____ To _____
14. Please list name and address of referring physician or any other physician who treated patient for this sickness or injury.
    Name _____ Address _____
    Name _____ Address _____

Physician's Name (Print) _____ Degree _____ Tax Identification Number _____

Physician's Signature _____ Date _____

Physician's Address (Street, City/Town, State or Province & Zip Code) _____ Telephone Number _____