Accident Claim Form

File claims using the Online Service Center (OSC) for faster payments, claim status updates, direct deposit and more.
Sign up or log in now!

Instructions for the Insured or Patient

- Complete the Statement of Insured (Sections A through F) as applicable to your claim.
- Completing Section G is not required; however, completing this section will reduce delays in processing should we need to request additional information regarding your claim.
- The following benefits require supporting documentation (refer to your Policy/Certificate for benefits covered under your plan.) The indicated documentation must accompany the completed Statement of Insured when filing a claim:
    - Organized Sports Booster Benefit, provide proof of registration in the Organized Sport Event
    - Accidental Injury Benefit, provide an Itemized Medical Bill[2]
    - Auto & Home Modification Benefit, provide an Itemized Invoice[4] or Itemized Receipt[5]
    - Family Care Benefit, provide a copy of the Itemized Medical Bill[2] for the hospitalization and Itemized Invoice[4] (Itemized Receipt[5]) for adult or childcare
    - Coma, Paralysis, Brain Injury, and/or Post-Traumatic Stress Disorder Benefits, provide Medical Records[1] and the completed Attending Physician's Statement
    - Accident Medical Expense Benefit, provide an Itemized Medical Bill[2] and a copy of the major medical carrier's explanation of benefits (EOB) for services rendered
    - Family Member Lodging and/or Non-Local Transportation Benefits, provide an Itemized Invoice[4] or Itemized Receipt[5] and Itemized Medical Bill[2]
    - Gunshot Wound Benefit, provide the Police Report
    - Motor Vehicle Accident, provide the Motor Vehicle Accident Report
    - Auto & Home Modification, provide an Itemized Invoice[4] or Itemized Receipt[5]
    - Prescription Drug Benefit, provide an Itemized Invoice[4] or Itemized Receipt[5]
    - Appliance Benefit, provide a Prescription[6]
    - Accident which resulted in death, provide the Death Certificate [3]
- Your signature is required for benefit consideration

[1]Medical Records should support diagnosis of the condition and include laboratory analysis, pathology report, imaging studies, other tests, and office notes.
[2]The itemized medical bill must include the diagnosis for which treatment was provided and the procedures that were performed. A copy of the standardized claim forms, commonly called a UB or CMS form, may be submitted in lieu of the itemized bill.
[3]Original copies of death certificate will be returned.
[4, 5] The itemized invoice, or itemized receipt, should include the service or item purchased, each date of service or date of purchase, charge amount, and vendor or company name, address location, and telephone number. The itemized invoice or itemized receipt should also include the origin and destination location when filing a claim for Repatriation and Non-Local Transportation.
[6]The Prescription should include a physician's written order authorizing a vendor to supply a specific appliance for a Patient, with instructions on its use.

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STATEMENT OF INSURED

Section A - About the Insured

First Name	MI	Last Name	Suffix

Date of Birth	Social Security Number **or** Policy Number(s)

Address	City	State	Zip Code

Home Phone Number	Cell Phone Number	Email Address

Section B – About the Patient

First Name	MI	Last Name	Suffix	Date of Birth

Section C - Details of the Accident

Date of Accident _____ **Location of Accident** **City** _____ **State** _____

In your own words, explain the injuries and how the accident occurred *(Include additional information on another page, if needed)*

Was the Patient in a motor vehicle accident?	☐ Yes	☐ No
Was the Patient in any other type of accident that required an incident report?	☐ Yes	☐ No
Was the Patient at work when the accident occurred?	☐ Yes	☐ No
Did the injury occur while participating in an Organized Sport?	☐ Yes	☐ No
Was the Patient treated in a hospital or medical facility owned, operated, or maintained by the policyholder?	☐ Yes	☐ No

Section D – Benefits Claimed – Select the Benefit(s) for which this claim is being filed

☐ Accidental Injury or Death	☐ Coma	☐ Non-Local Transportation
☐ Accident Medical Expense Benefit	☐ Family Care	☐ Organized Sports Booster
☐ Appliance	☐ Family Member Lodging	☐ Paralysis
☐ Auto & Home Modification	☐ Gunshot Wound	☐ Post-Traumatic Stress Disorder
☐ Brain Injury	☐ Motor Vehicle Accident	☐ Prescription Drugs

Section E – Non-Local Transportation

Begin Date of Travel	Method of Travel	Treating Location			
		Street	City	State	Zip

Family Member Lodging

Begin Date of Travel	Family Member's Address			Treating Location			Relationship to Patient
	City	State	Zip	City	State	Zip	

Acknowledgement - Your signature is required for benefit consideration

I hereby certify the answers I have provided in the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice included in this claim form.

Signature of Insured/Beneficiary _____ Date Signed _____

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Section F – 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.

For your protection **California** law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

For your protection **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.

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Section G - Authorization to Request Information Including Protected Health Information

The purpose of this form is to allow American Public Life Insurance Company (APL), or business partners acting on behalf of APL in the administration of APL 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, APL 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 APL 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. APL will only disclose any data collected pursuant to this authorization as necessary for 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 I may have been treated.

I understand APL may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand 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 APL not having enough information to process my benefits. I understand I may revoke this authorization at any time by writing to APL, P.O. Box 248950, Oklahoma City, OK 73124-8950 or by calling 800-256-8606. I understand that my right to revoke this authorization is limited to the extent that: APL has acted in reliance on the authorization; or the law provides APL 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 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 APL 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 APL.

For health insurance coverage, this authorization will expire 24 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 24 months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

APL Policy Number	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.

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ATTENDING PHYSICIAN STATEMENT

Instructions for the Physician

- Complete the Attending Physician's Statement (Sections H1 through H6) as applicable to your Patient.
- Send the signed Attending Physician's Statement and supporting documentation to the address or fax number listed above.

H1 - Patient Information

First Name	MI	Last Name	Suffix

Date of Birth	Social Security Number **or** Policy Number(s)

H2 - About the Diagnosis and Treatment

Primary Diagnosis Code or Description	Date of Diagnosis	Initial Treatment Date

Is the condition expected to be permanent? ☐ Yes ☐ No # of consecutive days condition has persisted?

Has the Patient ever had the same or a similar condition? ☐ Yes ☐ No If yes, date previously diagnosed

Describe the previous condition

Is the condition due to an accident? ☐ Yes ☐ No If yes, date of accident

Does this injury require a course of physical, speech, and/or occupational therapy? ☐ Yes ☐ No

If the Patient was referred to you, provide the contact details of the referring Physician

First Name		Last Name	
Contact Number		Address	
City		State	Zip Code

H3 – Brain Injury

Date of Diagnosis

Has the Patient experienced an injury that was caused by a traumatic blow to the head, neck or shoulders? ☐ Yes ☐ No

Has the Patient experienced a Glasgow Coma Scale score of 8 or lower as a result of this injury? ☐ Yes ☐ No

Has the Patient experienced a concussion as a result of this injury? ☐ Yes ☐ No If yes, date diagnosed

Will/Does this injury require treatment by a board-certified neurologist? ☐ Yes ☐ No

H4 – Coma

Date continuous state of unconsciousness began

Was the coma (check all that apply) ☐ Medically induced ☐ A direct result of alcohol/drug use ☐ Neither

H5 – Paralysis

Date of Diagnosis

Does the Patient have damage to the brain or spinal cord that resulted in complete permanent loss of use or movement of one or more limbs? ☐ Yes ☐ No If yes, indicate type of paralysis (check one) ☐ Uniplegia ☐ Paraplegia ☐ Quadriplegia

H6 - Attending Physician Information, Acknowledgement and Signature

Physician's First Name	Physician's Last Name	Degree	Specialty

Physician's Address	City	State	Zip

Physician's Telephone Number	IRS Identification Number

I hereby certify the answers I have provided in the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice included in this claim form.

Physician's Signature	Date Signed