Standard Security
Life Insurance Company
Independence Holding Group

NOTE: Please read this before submitting a claim.

Instructions for filling out an Accident Medical Claim form.

- The claim form must be completed and signed by the insured. Please indicate your Group or Association name on the claim form.
- Your Accident Medical plan requires that treatment must be sought within a specific time frame. Please refer to the Schedule of Benefits in your Certificate of Insurance for the "Initial Treatment Period".
- Proof of loss (Completed claim form and itemized bills) should be submitted **within 60 days of the accident**. Additional bills related to the accident should be submitted **within 60 days of treatment**.
- You are required to provide medical records documenting all treatment received from all treatment providers consulted within the timeframe beginning three months prior to your reported accident through present date. Lack of receipt of all medical records as noted above will result in a delay in the review of your claim.
- Please attach itemized bills to the claim form. A balance due bill from your provider is **not** sufficient. An itemized bill is a statement that indicates:
    1) The date(s) of treatment,
    2) The type(s) of service,
    3) The diagnosis,
    4) The medical provider's name and address,
    5) The individual charge for each expense.
- If you have other (primary) insurance coverage, please send us a copy of their payment or denial (Explanation of Benefits) statement. **Please note**: This is not necessary if you have purchased a "Primary" plan through Standard Security Life Insurance Company of New York that pays regardless of other insurance payments.
- Return the completed claim form, itemized bills and other insurance payment or denial (Explanation of Benefits) statements (if applicable) to

Ebix Health Administration Exchange Inc.
3925 East State Street Suite 100
Rockford, IL 61108
(866) 506-8664
Fax: (815) 316-6730

- Please indicate which bills have been paid by you. If you prefer payments to go directly to the medical provider, please complete and sign the authorization at the bottom of the claim form.
- A claim form needs to be completed only at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your name, group or association name, and date of accident.
- We suggest that you make photocopies of any correspondence sent to our office to keep for your own records.
- By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

IMPORTANT:
Please take note: delays in the processing of your claim will occur if all of the following have not been provided to our company: the completed claim forms, the itemized bills from your medical provider, and a copy of your other insurance payment or denial (Explanation of Benefits) statement.

PLEASE NOTE: Incomplete claim forms will result in a delay in the processing of your claim.

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GROUP ACCIDENT MEDICAL CLAIM FORM

TO BE COMPLETED BY THE INSURED:

Group Name: ______________________ Name of Insured: ______________________

Insured Date of birth: ______________________ Social Security number: ______________________

Address: ____

Street City State Zip Code

Telephone number: ______________________ Email address: ______________________

Patient's Name and Relationship (If other than Insured): ______________________

Patient's Date of birth: ______________________ ☐ Male ☐ Female

Date and time of accident: ______________________

Where did the accident occur (Please include specific address): ______________________

Please describe the Injury sustained as a result of the accident: ______________________

____

____

Please describe, in detail, the specific circumstances surrounding the accident: ______________________

____

____

Was this a work related accident / injury: ☐ Yes ☐ No Are you self employed: ☐ Yes ☐ No

Was a claim filed due to this accident / injury with your Workers' Compensation carrier: ☐ Yes ☐ No

If yes, please indicate the name and telephone number of your Workers' Compensation carrier: ______________________

____

If no, please explain why: ______________________

Have you ever had this condition before: ☐ Yes ☐ No If yes, please indicate month, date, and year: ____/____/____

Are you covered by any other plan (including Workers' Compensation) for expenses related to this accident: ☐ Yes ☐ No If yes, please provide the following information:

Insured / Member / Owner Name: ______________________

Carrier Name: ______________________

Address: ______________________

Telephone number: ______________________ Policy number: ______________________

Effective date: ______________________ Termination date (if applicable): ______________________

I hereby authorize Standard Security Life Insurance of New York to pay bills in connection with this accident directly to the Hospital or Other Medical Provider as indicated below: I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered by the policy

______________________ ______________________

Signature of Insured Date

______________________ ______________________

Hospital or Other Medical Provider Name Hospital or Other Medical Provider Name

______________________ ______________________

Address / Telephone number Address / Telephone number

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature______________________ **Date**______________________

ATTENDING PHYSICIAN'S STATEMENT

Thorough completion of this form will assist our company in completing a timely review of your patient's claim. This form must be completed by a physician.

Name of patient:______________________________

Date of birth:______________________ Social Security Number:______________________

DIAGNOSIS

Primary diagnosis:______________________________ ICD-10 code:__________

Secondary diagnosis:______________________________ ICD-10 code:__________

Other diagnoses and ICD codes related to this claim:______________________________

This condition is the result of an ☐ Illness ☐ Accident If an accident; on what date did the accident occur: __________

If an accident, how do you understand the accident occurred:______________________________

Has your patient ever had the same or similar condition? ☐ No ☐ Yes If yes, indicate when and describe:______________________________

On what date were you first consulted for this condition:______________________________

Please provide the five most recent dates of treatment:______________________________

If patient was hospitalized, please provide dates: Admitted__________ Discharged__________

Admitting diagnosis:______________________________ ICD-10 code:__________

Discharge diagnosis:______________________________ ICD-10 code:__________

Name of hospital:______________________________

Name of doctor seen at hospital:______________________________

Address:______________________________

Street City State Zip Code

Was this patient referred from another physician ☐ No ☐ Yes If yes, please indicate the name and address of the referring physician:

____

Was surgery performed? ☐ No ☐ Yes If yes indicate procedure and date of surgery: ______________________________

PLEASE READ CAREFULLY

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Physician's signature:______________________________ **Date:**__________

Physician's name (please print):______________________________ Specialty:__________

Address:______________________ City:__________ State:__________ Zip Code:__________

Phone number:______________________ **Medical record department fax number:**__________

Fraud Warnings

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states and the District of Columbia: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: 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 WARNING: 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.

COLORADO WARNING: 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 damage. 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.

FLORIDA WARNING: 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 WARNING: 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.

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

NEW YORK WARNING: 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 $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: 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.

WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.