

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) (La	st)	Social Security #		
Claimant/Patient Nam	ne (First) (Middle	e) (Last)	Relationship to Insured Self [] Spouse[Child []	Male []	Age Date of Birth (mm/dd/yy)		
Policyholder Home Ad	ddress (Street)	(Apt)	(City)	(State	(Zip)		
Home Telephone Numb		Email Address		application? \	red since your policy res[] No[] e your new address?		
	CHECK OFF THE	BOX FOR THE BENE	FIT(S) BEING (CLAIMED			
CHECK OFF THE E 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 Poental Work Emergency Room Treatment Hospital Admission Hospital Confinement/Day Hospital ICU Admission Hospital ICU Admission Hospital ICU Admission Hospital ICU Admission Plospital ICU Admission Hospital ICU Admission Pospital ICU Admission Pospital ICU Admission Initial Office Visit Major Diagnostic Exam Medical Appliances Pain Management/Epidural Physical Therapy per day Prosthetic Device/Artificial Limb Rehabilitation Unit per Day		Section Three (Refer to SECTION THREE Instructions Below) []Transportation [] Lodging			
Describe below the be	enefit(s) you are claiming	INSTRUCTIONS					

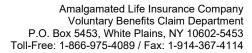
SECTION ONE: Complete the Claim Information Section and have your physician complete the Attending Physician's Statement. Submit proof of the type of injury claimed. This can be a surgery bill, an operative report, or other documentation that proves/describes the type of injury.

SECTION TWO: Complete the Claim Information Section 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 inform lodging expense. The Attending Physician's S		g questions. Submit proof of travel expense and/or		
	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 SEC	TION		
Date of Accident	Time of Accident	Location of Accident		
Provide details of Accident				
Were you hospitalized? YES [] NO []	If yes, provide date	es and name of facility		
Include a copy of the hospital bill with this clair Was the accident related to a motor vehicle acc Describe what occurred.	m, if available, or any other supporting sident or other accident investigated by a	documents. any law enforcement agency? YES [] NO []		
Name of Agency				
Note: If the injury was a result of an automorprovide the police report.	obile accident or other accident inve	estigated by any law enforcement agency, you must		
	CLAIMANT CERTIFICATION	ON		
	FOREGOING STATEMENTS, INCLUI	THE PERIOD COVERED BY THE CLAIM, THAT THE DING ANY ACCOMPANYING STATEMENTS, ARE TO		
	FRAUD WARNING			
application for insurance is guilty of a crime ar	nd may be subject to fines and confiner	·		
	r, Maine, Maryland, Minnesota, New Ha	Alaska, Arizona, California, Colorado, Delaware, District ampshire, New Jersey, New York, Ohio, Oklahoma,		
Claimant Name (Print)				
Signature Date				
ΔΙ	JTHORIZATION TO RELEASE IN	FORMATION		

AUTHORIZATION TO RELEASE INFORMATION

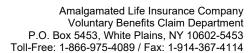
Read, sign and date the Authorization for Release of Health Care Information Pursuant to HIPAA on page three (3), and provide a copy to your treating physician. Submit a copy to Amalgamated Life Insurance Company along with your claim.





Voluntary Benefits - Accident Insurance AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Social Security #			
Address	Date of Birth			
	formation regarding my care and treatment be released as set forth on this form. ortability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 290dd-2 and its implementing			
pharmacy or other medically related facility or service; health about my health, employment history, or other insurance clai	ider including, but not limited to, any health care professional, hospital, clinic, laborator plan; rehabilitation professional; vocational evaluator; and employer that has informations and benefits to disclose any and all of this information to persons who administer an including Amalgamated Medical Care Management (AMCM), an affiliate of Amalgamate			
Confidential HIV Related Information, only if I place my initials any of these types of information, and I initial the line on the b	ng to: Alcohol and Drug Abuse, Mental Health Treatment, except psychotherapy notes, and on the appropriate item below. In the event the health information described below includions in the item below, I specifically authorize release of such information to Amalgamate Management (AMCM), an affiliate of Amalgamated Life Insurance Company.			
<u>IMPORTANT</u> – Please complete the check boxes be medical records.	low even if the categories should not necessarily apply to the patient's			
□ Do □ Do Not want information about Mental H □ Do □ Do Not want information about HIV Test □ Do □ Do Not want information about Alcohol a	is & Related Information released (initial)			
prohibited from re-disclosing such information withou	l, or drug treatment, or mental health treatment information, the recipient is it my authorization unless permitted to do so under federal or state law. I cople who may receive or use my HIV related information without			
claim(s) for disability benefits, which may include assisting	M obtains pursuant to this authorization will be used for evaluating and administering n me in returning to work. I further understand that authorized recipients to my medic sclose my medical documentation without the need to obtain additional written conserbe protected by federal or state law.			
	y treatment, payment, enrollment in a health plan, or eligibility for benefits will not leaver, if I do not authorize release of my medical information, this may result			
that my revocation will not be effective until received by Ar "Information" that has been made prior to receipt of my revo	oviding written notice of revocation to Amalgamated Life Insurance Company. I am awa malgamated Life, and will not be effective regarding the uses and/or disclosures of n cation. This authorization is valid for one year from the date below or the duration of n by of this authorization is as valid as the original. I understand I am entitled to receive			
This authorization does not authorize my medical provider t Life Insurance Company or AMCM.	to discuss my health information or medical case with anyone other than Amalgamate			
>				
Patient's Signature or representative authorized by law	Date			
If other than patient: I signed on behalf of the patient as If Power of Attorney Designee, Guardian, Conservator, plea	(relationship).			





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

		Attend	ing Physician's S	Statement				
		POLICYHOL	DER/CLAIMANT	INFORMATION				
Policy Number	Policyholder/Insured Name (First) (Middle) (Last)					Social Security Number		
Claimant/patient No.	ame (First)	(Last)	Relationship to Insured Self [] Spouse [] Child []	Gender Male [] Female []	fale [] (mm/dd/yy)			
		F	PHYSICIAN SECT					
Date of Injury			Type of Inju	ry				
Dates of Treatmen	for this injury							
Describe the type of	of treatment you prov	ded for this injury						
Diagnosis Descript	ion (include all relate	d diagnoses)	Diagnosis (Code(s)				
Diagnosis Dossinpt	on (moduce an rolate	a diagnosso,	Diagnosis ((6)				
If patient was hosp	patient was hospitalized, date of confinements and reasons If Patient had surgery, date and type of surgery							
Indicate the type of details	injury from the list in	Section One of Accid	lent Claim Form (pa		ent has incurr	ed and p	rovide specific	
application for insu For residents in the District of Columbia	rance is guilty of a cr following states, ple a, Florida, Idaho, Indi	alse or fraudulent clair me and may be subje ase see the last page ana, Kentucky, Maine essee, Texas, Virgini	n for payment of a le ect to fines and confi of this form. Alaban , Maryland, Minneso	oss or benefit, or k nement in prison. na, Alaska, Arizon	a, California,	Colorado	o, Delaware,	
		PHYSICIAN CEF	RTIFICATION A	ND SIGNATUF	RE			
Physician name	e (print)		De	gree/Specialty				
Street Address			City	Sta	ate	Zi	p	
_		Fax No.						
Signature	Signature Date							



FRAUD WARNINGS FOR CLAIM FORMS

Alabama 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 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 Department of Regulatory Agencies – Division of Insurance.

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.

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 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.

Ohio Residents: Any person who, with intent to defraud or knowingly 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.

Virginia Residents: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or fraudulent statement may have violated state law.