PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

POLICY #_____

CERT.# _____

SOCIAL SECURITY # _____

P.O .Box 4884
Houston, TX 77210-4884

ACCIDENT CLAIM FORM

INSTRUCTIONS:
1. Please make sure all questions on this page are answered completely.
2. Sign and date the authorization on page three (3). Please return a copy to us along with the completed claim form. You may want to retain a copy for your records.
3. Please attach itemized hospital bills, physician bills and other documentation of expenses. Make sure all bills indicate a diagnosis code, procedure code, date of service and cost. Prescription receipts must furnish date, patient name, name of medication and name of prescribing physician
4. Please retain a copy of your claim submission for your records.

Primary Insured's Full Name: _____ Date of Birth: _____/_____/_____

Full Address: _____

□ Check if this is a new address

Daytime Telephone Number: (_____) _____ Evening Telephone Number: (_____) _____

Patient's Full Name (if other than the insured): _____ Date of Birth: _____/_____/_____

Social Security Number: _____ Relationship to Insured: _____

Full Address (if different than insured): _____

Daytime Telephone Number: (_____) _____ Evening Telephone Number: (_____) _____

If claim is for a child, please mark all that apply:

□ Unmarried □ Qualified as a dependent of your or your spouse for tax purposes according to the U.S. Internal Revenue Code

□ Full-time student over 18 years old. Provide the name of the school and the number of hours per semester:_____

□ Employed full time. Provide employer's name and address: _____

INJURY DESCRIPTION

Date and time of the accident: _____/_____/_____

_____:_____ AM/PM

Explain the injuries and how the accident happened:

_____

_____

_____

_____

_____

_____

_____

_____

INJURY CAUSE INFORMATION

1. Was injury work related? □ Yes □ No
2. Did injury occur on someone's premises? □ Yes □ No
3. Was injury due to an act of violence? □ Yes □ No
4. Was injury due to a faulty product? □ Yes □ No

   Name and description of faulty product:

   _____

   _____
5. Was injury due to a Motor Vehicle Accident? □ Yes □ No

If "Yes", please complete Motor Vehicle Accident Information Section and provide a copy of the Police Motor Vehicle Accident Report.

CONTACT INFORMATION

Police Department or Emergency Service who provided assistance:

Name:_____

Address: _____

Telephone Number: (_____)_____

Treating Physician:

Name:_____

Address: _____

Telephone Number: (_____)_____

Patient's Attorney:

Name:_____

Address: _____

Telephone Number: (_____)_____

MOTOR VEHICLE ACCIDENT INFORMATION

1. Was the Patient driving? ☐ Yes ☐ No
2. Was the Patient a passenger? ☐ Yes ☐ No
3. Was the Patient a pedestrian? ☐ Yes ☐ No
4. Was another vehicle involved? ☐ Yes ☐ No

Insurance Company for Patient's vehicle:
Name and Address: _____
Insurance Agent (name and telephone number): _____
Policy Number: _____

Insurance Company for other Driver's vehicle (if applicable):
Name and Address: _____
Insurance Agent (name and telephone number): _____
Policy Number: _____

OTHER

Please provide any other information regarding this injury that you believe may be helpful:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I certify that the statements and answers on this claim form are true and correct. 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 is guilty of a crime and my be subject to fines and confinement in prison. I also certify that I have read my current residential state fraud warning on the attached Claim Fraud Warning page if my state is listed on that page.

Patient's signature (if minor, parent signs) _____ Date: _____/_____/_____

Primary Insured's signature _____ Date: _____/_____/_____

If you have any questions please call our Claims Department at 888-748-3040 Ext 1331
Completed Claim Forms and Documentation can be mailed, faxed or emailed to our offices.

Philadelphia American Life Insurance Company
Attention: Claims Department
PO Box 4884
Houston, TX 77210-4884

Fax: 281-368-7382 *Email: claimsdepartment@neweralife.com*

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. Box 4884 • Houston, Texas 77210 • (800) 713-4680

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

Applicant / Primary Insured Name | Policy / Certificate # (if applicable) | Phone #

Address (Street, City, State, Zip)

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist, Pharmacy Benefit Manager or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Philadelphia American Life Insurance Company (PALIC) or its agents, employees, designees, or representatives, including my PALIC agent or broker.

Purpose of this Authorization: By signing this form, you will authorize PALIC to use and/or disclose your Protected Health Information (PHI) to determine if your application will be approved for health insurance or that you are eligible for benefits. This authorization is a condition of your approved application for our health insurance or your eligibility for benefits.

You also will authorize PALIC to obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

Effect of Declining: If you decide not to sign this authorization, we may decline to approve your application for health insurance or to provide benefits.

This authorization may facilitate our consideration of a claim. If you decide not to sign this authorization, it may delay the processing of a claim.

Effect of Granting this Authorization: The PHI to be used and/or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon the termination of any PALIC coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Philadelphia American Life Insurance Company, P.O. Box 4884, Houston, TX. 77210-4884.

I understand that revocation of this authorization will not affect any action PALIC took in reliance on this authorization before PALIC received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

Print Name of Applicant or Claimant | Signature of Applicant or Claimant (parent if minor) | ____/____/____ Date

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

Personal Representative: Print Name | Please indicate Representative's relationship to Applicant/Insured and briefly describe Representative's authority to act for Applicant/Insured.

Signature | _____/____/_____ Date

A photocopy of this authorization is as valid as the original, and you and your PALIC agent or broker are entitled to receive a copy of this form.

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

STATE FRAUD WARNING NOTICES

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.
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
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	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
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.
IDAHO	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony
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.
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.
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.
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 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
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.
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.
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.
OREGON	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 may be 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 with the penalty of 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
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 include imprisonment, fines and denial of insurance benefits.
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.