PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

POLICY # 6810009292

CERT.# _____

SOCIAL SECURITY # 8484904-4

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

Medical Expense Policy
Claim Form

INSTRUCTIONS:
1. Please make sure all questions on this page are answered completely.
2. Sign and date the authorization on page two (2). 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. Original bills must be submitted. If you make photocopies they should be retained for your file.

1. Primary Insured's Full Name: Jane Doe

2. Primary Insured's Date of Birth: ____/____/____

3. Patient's Full Name:

4. Full Address: ☐ Check if this is a new address
11 Main Street

Daytime Telephone (____)_____

5. Patient's Date of Birth: ____/____/____
Relationship to Insured:
☐ Self ☐ Spouse
☐ Child ☐ Other

6. Are you or any member of your family covered by other insurance?
☐ Yes ☐ No
If yes, please provide:
Insured's name: _____
Company name and address:
_____
_____
Policies or Group number: _____
Type of coverage: ☐ Group ☐ Individual
Are any benefits payable under Medicare? ☐ Yes ☐ No

7. Is condition related to:
Employment: ☐ Yes ☐ No
Auto Accident: ☐ Yes ☐ No
(If due to a motor vehicle accident, please attach a copy of the police report)

8. Is this condition covered by Worker's Compensation?
☐ Yes ☐ No

9. Is Dependent employed?
☐ Yes ☐ No
In School full time?
☐ Yes ☐ No
If yes, please provide school or employer name and address:
_____
_____
Expected graduation date:
____/____/____

10. Nature of condition requiring treatment:
_____
_____
If sickness, date of first symptom:
____/____/____
Has this condition occurred before? ☐ Yes ☐ No

11. If injury, provide exact date and time:
____/____/____ Time: ____:____ AM/PM
How and where did the injury occur?
_____
_____

12. Furnish name and address of the physician first consulted for this condition:

I certify that the above 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 may 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: X _____ Date: ____/____/____

Either send to: claimsdepartment@neweralife.com or fax to: 281-368-7382

For claims questions call toll free 888-748-3040 Ext 1331

or Mail to: Philadelphia American Attention: Claims Department PO Box 4884 Houston, TX 77210-4884

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. Box 34952, Omaha, NE 68134-9832 (800) 554-0092

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 34952, Omaha, NE 68134-9832.

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.

X _____ X _____ ____/____/____

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.