

THE BENEFIT BRIDGE® CLAIM FORM



FIDELITY SECURITY LIFE INSURANCE COMPANY

MAIL TO: Fidelity Security Life Insurance Company
3130 Broadway, P.O. Box 418131
Kansas City, MO 64141-9131

CHECKLIST

1. Complete STATEMENT OF INSURED below, answering all questions fully.
2. ATTACH EXPLANATION OF BENEFITS (EOB) provided by the insurer for your Comprehensive Major Medical Plan, if applicable, to this claim form.
3. Attach copies of all itemized bills. Bills must indicate date, place of service and diagnosis.
4. Return this claim form, all itemized bills and EOBs to the address shown above.

STATEMENT OF INSURED

Your Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		
Policy Number		Social Security Number			
Your Address (Number and Street)		City	State	Zip Code	
Name of Patient			Date of Birth		
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter					
Describe Injury or Sickness Completely <i>(If injury, describe how accident occurred)</i>					
Date of Injury or Beginning of Sickness:					
Name and Address of Physician Who First Treated This Condition					Date First Treated
Is Injury or Sickness Due to Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			Will You or Your Dependent File for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you or your dependent covered under any other insurance plan (including Blue Cross & Blue Shield), Student Accident, Hospital Indemnity or Government plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes", please specify insurance carrier's name, address, policy number and daily benefit amount, if applicable, for any other insurance plan that you currently have, or any plan that has terminated since the effective date of your coverage under The Benefit Bridge.					
Name of Company	Address	Coverage Type	Policy Number	Benefit Amount	Termination Date (if applicable)
<p>NOTE TO ALL PARTIES COMPLETING THIS FORM: 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.</p> <p>I certify that the information given by me in support of this claim is true and correct.</p>					
Insured's Signature				Date	

IMPORTANT! PLEASE COMPLETE THE AUTHORIZATION ON REVERSE SIDE OF THIS FORM



P.O. BOX 418131 • 3130 BROADWAY • KANSAS CITY, MO 64141-9131
800-648-8624 (ALL AREAS) • FAX 816-968-0580

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

I authorize the disclosure of health information regarding, or related to:

Name: _____ Date of Birth _____ Policy No. _____
Claim No. _____

- I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This Authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.
- I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this Authorization does not authorize the release of psychotherapy notes.
- I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.
- I authorize Fidelity Security Life Insurance Company, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this Authorization.
- The purpose of the disclosure authorized herein is to permit Fidelity Security Life Insurance Company, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to administer the above-referenced individual's health insurance coverage.
- This Authorization shall expire twenty-four (24) months after the date on which it is executed below.
- I understand that eligibility for the health plan is conditioned on my execution of this Authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.
- I understand that I may revoke this Authorization by sending written notice of my intent to revoke this Authorization to 3130 Broadway, Kansas City, MO 64111, Attention Privacy Officer.
- I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.
- A copy or facsimile of this Authorization shall be as valid as the original.

Signature of the individual or the individual's personal representative

Date

If signed by the individual's personal representative (e.g. a parent on behalf of a child), describe your authority to sign on behalf of the individual