FREEDOM LIFE INSURANCE COMPANY OF AMERICA

Association Accident Claims Unit
P.O. Box 549
Fort Worth, Texas 76101
1-800-387-9027

BLANKET ACCIDENT CERTIFICATE CLAIM FORM

HOW TO FILE A CLAIM

1. The insured should complete this side of the form in its entirety.
2. You must attach itemized bills for medical expenses such as hospital, or any other covered charge.
3. You must attach Explanation of Benefits forms from any other insurance carrier that provides coverage for this or any other expenses you may have.
4. Forward your completed form, bills and other insurance Explanation of Benefit forms to the address shown above.

INSURED'S STATEMENT

I hereby apply for benefits for ☐ Self ☐ Spouse ☐ Child

1. Insured's name in full_____ Date of Birth _____ Sex ☐ M ☐ F
2. Street and No._____ City _____ State _____ Zip _____
3. Coverage Identification Number (if known) _____
4. If claim is on a dependent, complete "a" "b" and "c":
   (a) Name _____ Relationship _____ Date of birth _____
   ☐ Single ☐ Married
   (b) If employed, name of employer _____
   (c) If child over age 18, name of school or college attending _____
5. Details of accident: Date _____ and time _____ ☐ AM ☐ PM
   Where did injury occur? _____ At Work? ☐ Yes ☐ No
   Describe how the injury occurred. Provide all possible details. Must be a bodily injury due to accident.
   _____
   _____
6. Are you (the insured) employed? ☐ Yes ☐ No
7. Are you or any of your dependents insured or eligible for insurance benefits under a group policy or group-type coverage (including Medicare) or under any other accident / health insurance plan?

   ☐ Yes ☐ No

   If yes, furnish the name and address of insurance company and policy number:

   Company Name _____ Policy Number _____
   _____ _____
   _____ _____

   Was 3rd party insurance coverage such as auto insurance, homeowner's liability, commercial liability, etc involved in the handling of these expenses?

   ☐ Yes ☐ No If yes, name of policyholder _____

   If yes, please furnish name and address of insurance company _____ Policy No._____

(SEE OTHER SIDE)

Authorization for Release of Information

I authorize the release of information (as defined below) to Freedom Life Insurance Company of America or any person or entity acting on its part: any medical professional, medical care institution, pharmacist, insurer, reinsurer, government agency (including departments of public safety and motor vehicle departments) consumer reporting agency or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Freedom Life Insurance Company of America deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Freedom Life Insurance Company of America for the purpose of evaluating claims for benefits may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Freedom Life Insurance Company of America to evaluate claims for benefits. I understand authorizing the use or disclosure of the information identified above is voluntary, I need not sign this form to ensure healthcare treatment.

I understand that I may revoke this authorization at any time, except to the extent that (1) Freedom Life Insurance Company of America has taken action in reliance on this authorization, or (2) other law provides Freedom Life Insurance Company of America with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to the Company Privacy Official, 3100 Burnett Plaza, 801 Cherry Street, Unit 33, Fort Worth, Texas 76102

I may obtain a copy of the signed authorization by submitting a written request to the Company Privacy Officer at the address shown in the preceding paragraph.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

_____ _____

(Date) **(Name of Patient)**

_____ _____

(Claimant or Parent/Person Legally Responsible if Claimant is a Minor) **(Relationship)**

I hereby certify that all of the above information is true and complete.

_____ _____

(Signature) **(Printed Name)**

NOTE:

If a personal representative on behalf of an individual has signed this authorization, his/her authority to act of behalf of the individual must be identified here:

_____

_____

_____

_____

Important Claim Notice – Fraud Statement

California 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.

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.

Ohio Residents: 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.

Tennessee 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 include imprisonment, fines and denial of insurance benefits.

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.

For all States Other than those mentioned above: 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.