CLAIM FORM
FOR ACCIDENT AND HEALTHCARE INDEMNITY PLANS

PO Box 83043 ▪ Lincoln, NE 68501-3043 ▪ 866-863-9753 ▪ Fax: 402-479-0146

If filing a claim for Wellness Screening Benefit or RX Benefit* no form is needed, please call 866-863-9753.
* When you call, it is helpful to have your pharmacy receipt on hand for quick reference.

POLICY INFORMATION

Certificate Number			
Policy Owner Name		SSN	
Mailing Address			
Email Address		Phone	
Date of Birth (MM/DD/YY)		Employer/Group	

PATIENT INFORMATION

Patient/Insured Name *(if different from owner)*			
Mailing Address *(if different from owner)*			
Email Address		Phone	
Date of Birth (MM/DD/YY)		☐ Male	☐ Female
Relationship to Policy/Certificate Owner			

CLAIM INFORMATION

Claim Type (mark all that apply)

☐ ER/Hospitalization ☐ Accident ☐ Doctor's Visit or Follow Up ☐ Lodging Benefit

If filing a claim on your Group Accident Policy, please provide the following details:

Date of Accident		Location	

Describe how the accident happened: (include a separate piece of paper if needed):

_____

_____

_____

Supporting Documentation Needed:

- Itemized bill from hospital stay (UB92/04) with CPT or ICD9-10 Codes to determine benefit.
- Itemized bill from physician's office (HCFA 1500)
- Accident/MVA/Police Report (if claim is related to a motor vehicle accident)
- Receipts or Explanation of Benefits for X-Ray/Diagnostic Tests with dates and charges (if applicable)

Completed and signed Authorization to Disclose Health Information form on page 5

SIGNATURE AND ACKNOWLEDGEMENT

By signing below, I acknowledge:

1. AII information I have given is true and complete to the best of my knowledge and belief.

2. I have read the applicable Fraud Warning(s) provided in this form. 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 claim for each such violation.*

Under penalty of perjury, I certify:

1. That the number shown on this form is my correct taxpayer identification/social security number are true and accurate; and,

2. That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and,

3. I am a U.S. citizen, or a U.S. resident for tax purposes. Please note: If item 2 or 3 above is not true, cross out the applicable item(s). The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding.

Signature of Insured or Authorized Representative

Date of Birth (MM/DD/YY)

Please print name of Insured or Authorized Representative

If signed by Authorized Representative, describe your authority and provide documentation.
(e.g., guardian, conservator, power of attorney, etc.)

HOW TO SUBMIT A CLAIM

Next Steps:

- Please gather this completed and signed Claim Form and all supporting documentation listed on page 1. See below to submit your claim
- We're here to help! If you have any questions or need assistance, please call us at 1-866-863-9753.

By Mail	5Star Life Insurance Attn: Health Claims Department PO Box 83043 Lincoln, NE 68501	By Fax	402-479-8924

Fraud Warnings and Certifications

Before signing the claim form above, please read the warning for the state where you reside and the state where the insurance policy under which you are claiming a benefit was issued.

STATE	FRAUD STATEMENT
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 false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in 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.
DISTRICT OF COLUMBIA	***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	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 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	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 ***NH Rev. Stat. Ann. §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 knowingly 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.
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 ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are [sic] 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.
RHODE ISLAND	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.
TENNESSEE	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	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	Any person who, with the 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 have violated the State Law.
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.

Authorization to Disclose Health Information

Instructions for completing this form

- Complete all applicable areas of the form; sign this form; provide a copy along with the Physician's Attachment to your physician.
- If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf.

Your refusal to complete and sign this form may affect your eligibility for benefits under your accident insurance policy.

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For purposes of determining my eligibility for hospital indemnity benefits, the administration of my hospital indemnity plan, and the administration of other benefit plans in which I participate that may be affected by my eligibility for hospital indemnity benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contract holder or benefit plan administrator to disclose to 5Star Life Insurance Company (“5Star Life”), my employer in its capacity as administrator of its accident benefit plan, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on 5Star Life’s behalf, any and all information about my health, medical care, employment, and accident claim.
2. **I permit** 5Star Life and my employer (if applicable) to disclose in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and accident claim.

This Authorization to Disclose Health Information specifically includes my permission to disclose my entire medical record, including medic,1) information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

I understand that I may revoke this authorization at any time by writing to 5Star Life, P.O. Box 68501, Lincoln NE 68501-3043, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

Please print name of Patient or Authorized Representative (First, MI, Last)	Date of Birth (MM/DD/YY)

If signed by Authorized Representative, describe your authority and provide documentation
(e.g. guardian, conservator, power of attorney, etc.)

Signature of Patient or Authorized Representative	Date (MM/DD/YY)