CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

ACCIDENT CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.
To prevent delays, please provide documentation from your healthcare provider to support this claim.
Please review your policy for specific benefits covered under your plan.

- ✓ **Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.**
- ✓ **If this claim is for an individual covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.**

AUTHORIZATION

Several states require that the following statement appear on the claim forms:
Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this form.

Policyholder's Signature: ______________________________ Date: ________________

Patient's Signature: ______________________________ Date: ________________

PART A — POLICYHOLDER/PATIENT'S INFORMATION

1	EMPLOYER'S NAME			POLICYHOLDER'S EMAIL ADDRESS	
2	POLICYHOLDER'S NAME	POLICY NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER
3	POLICYHOLDER'S ADDRESS STREET		CITY	STATE	ZIP CODE
	☐ CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE.				
4	PATIENT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	GENDER	POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)	
5	RELATIONSHIP TO POLICYHOLDER				

Please sign the attached HIPAA Form and return it with the completed claim form.

- Date of the Injury: ____________________________
- Describe how the injury occurred: ____
  ____
- Location of the injury? ☐ On the job ☐ Off the job
  - Has a Worker's Compensation claim been filed? ☐ No ☐ Yes
    - If yes, status of the claim: ☐ Approved ☐ Pending ☐ Denied
- Was the patient injured in a motor vehicle accident? ☐ No ☐ Yes (If yes, please submit the Police Report)

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- Was death a result of this injury? ☐ No ☐ Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)

- Was the patient confined to the hospital as a result of this injury? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Admission date: ______________________________Discharge Date: _____________________________________

  Hospital name: ____

  City: _________________________ State: _______________

- Was the patient transported by an ambulance as a result of this injury? ☐ No ☐ Yes (If yes, please submit the ambulance bill)

- If any of the following were the result of your injury, please provide medical records or physician's office notes:
  - Coma
  - Paralysis
  - Degree of Burn
  - Injury to the Eye
  - Laceration (including length and method of repair)
  - Dislocation (X-ray reports or major diagnostic exam reports are needed)
  - Concussion (Major diagnostic exam reports are needed)
  - Fractures (X-ray reports or major diagnostic exam reports are needed)

- Was an aid in locomotion (mobility) prescribed as a result of this injury? (i.e. Crutches, Wheelchairs, Leg Braces, Walking Boots, Back Braces, Walkers, Cervical Collars) ☐ No ☐ Yes (If yes, please submit documentation from the prescribing provider.)

- Your policy covers the following surgeries:*
  - Open Reduction, Internal Fixation (Fractures or Dislocations)
  - Ruptured Disc Repair
  - Knee Cartilage Repair
  - Tendon or Ligament Repair
  - Open Abdominal/Thoracic Surgery
  - Eye Surgery
  - Were any of these surgical procedures performed as a result of this injury? ☐ No ☐ Yes (If yes, please submit a copy of the operative report.)

- Was a major diagnostic exam (i.e. CT Scan, MRI, MRA, EEG) performed as a result of this condition?
  ☐ No ☐ Yes (If yes, please submit a copy of the exam report or billing.)

- Provide all dates of treatment related to injury on the lines below (please submit supporting medical documentation for each visit indicated below):*
  - Initial date of treatment:________________________________
  - Follow ups:____
  - Physical Therapy:____

See policy for time limit provisions.

INSURED____ POLICY NUMBER______________________________________

AUTHORIZATION TO OBTAIN INFORMATION
CONTINENTAL AMERICAN INSURANCE COMPANY

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, or any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

______________________________________ ______________________
(Printed Name of Individual Subject to Disclosure) (Date of Birth)

______________________________________ ______________________
(Signature) (Date Signed)

If applicable, I signed on behalf of the insured as ______________________________________.
(Indicate relationship, legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.)

____
(Printed Name of Legal Representative)

______________________________________ ______________________
(Signature of Legal Representative) (Date Signed)