Liberty Bankers®
Insurance Group | *Liberty Bankers Life*

SUPPLEMENTAL HEALTH CLAIM FORM INSTRUCTIONS

Please refer to your policy for a list of benefits covered under your plan. Covered services vary by plan.

Note: Your policy may contain waiting periods and a pre-existing conditions limitation. Please refer to your policy pages for more information on your plan. A claim occurring during the first 2 years of the policy may require additional information. If we need additional information, we will notify you in writing.

TO PREVENT POSSIBLE DELAYS IN PROCESSING YOUR CLAIM, PLEASE PROVIDE ALL REQUESTED INFORMATION:

- **Claim Form:** Complete the appropriate claim form in its entirety including the description of the loss and how it occurred along with insured signature.
- **Standardized Billing Statement:** Submit a UB-04 for hospital stays, HCFA for physician services, or an itemized billing statement from your provider. Ensure the statement contains dates of service, diagnostic codes, procedure codes, and amount charged.
- **Provider Information Sheet:** When submitting a claim within the first 2 years, include all providers seen within the past 5 years. Failure to complete Provider Information Sheet may delay the processing of your claim.
- **HIPAA Compliant Authorization to Release Confidential Medical Information Form:** Ensure the insured reviews and signs this form.
- **Dental, Vision, and Hearing Claim Form:** Submit this form when you have a Dental, Vision, or Hearing claim.

FAQ

Q: How long do I have to submit my claim?
A: Written proof of loss must be provided no later than 12 months from the date of loss.

Q: How long should a customer expect to wait for a claim to be paid?
A: Once the claim is in good order, it can take up to 10 business days for the claim to be processed.

Q: If I cannot get a Standardized billing statement (UB04 for hospital stay or HCFA for any physician services), what should an itemized statement include?
A: An itemized statement must include:

1. ICD-CM Diagnosis codes (reason for treatment)
2. CPT and/or HCPCS Procedure Codes (services provided)
3. Admission and discharge dates or dates services were provided

Liberty Bankers®
Insurance Group | *Liberty Bankers Life*

FAQ (CONTINUED)

Q: What needs to be submitted to process a wellness claim?
A: A completed claim form along with proof that services were rendered. This can include:

- Itemized statement or HCFA
- Copy of EOB from primary insurance
- Copy of receipt showing services rendered
- Findings report for service (e.g., mammogram results, doctors visit notes for annual Medicare well visit)

Q: What is a pre-existing condition?
A: It is an Injury or Sickness, disclosed or not disclosed on the application, for which medical care, treatment, diagnosis or advice, or any diagnostic procedure or screening was received or recommended from a Physician within the 6 month period immediately prior to the Policy Effective Date of coverage under this Policy OR a condition that manifests itself within the 6 months prior to the Policy Effective Date of coverage under this policy in such a manner that it would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. Treatment includes, but is not limited to, being prescribed drugs or taking prescription drugs.

Q: What is Walker Claims Investigations?
A: Walker Claims Investigation is a third-party vendor contracted by LBIG to help obtain medical records when they are needed to adjudicate claims.

Q: Do I need to sign a new HIPAA form with each claim or complete a new provider sheet every time I submit a claim?
A: The HIPAA form is only valid for a maximum of six months from the date of signature. This form is only required for the first two years following the policy effective date. The provider sheet is also only required during the first two years of the policy, and a new form is only needed if there are additional providers not disclosed on the previously submitted form. After your policy has been in force for two years or longer you no longer need to complete either form.

Q: I have more than one policy with LBIG. Do I have to fill out more than one claim form if I am filing a claim on more than one policy?
A: The claim form required will depend on the claimed condition. For example, if you have a Cancer plan and an Accident plan and you get injured, you only need to submit the Accident claim form and submit the documentation required for processing. If you have a Hospital Indemnity plan and have Dental, Vision, and Hearing coverage and you are filing a Dental claim, you only need to complete the Dental, Vision, and Hearing claim form, unless you are also trying to get reimbursed for hospital confinement at the same time, then you would need to complete both forms and submit with appropriate documentation.

Administrative Address
PO Box 17628. Winston-Salem, NC 27116
Toll-Free (833) 658-2844
Claims Fax (336) 464-2961
Claims Email: supphealthclaims@lbig.com

Liberty Bankers®
Insurance Group | *Liberty Bankers Life*

ACCIDENT POLICY AND RIDER CLAIM FORM

PART ONE

Section A. General Instructions

- To prevent delays, please ensure all applicable sections of the form are completed and provide supporting documentation from your healthcare provider.
- Please review your policy for specific benefits covered under your plan.
- Claim forms and supporting documentation can be submitted via fax **(336) 464-2961** or email **supphealthclaims@lbig.com.** Emailing documents can facilitate in quicker claim processing.

Section B. Insured Information

FIRST	MI	LAST	POLICY NUMBER
STREET ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP	PHONE NUMBER ( )
EMAIL ADDRESS			

Section C. Covered Person or Dependent Incurring Accident or Injury

FIRST	MI	LAST	DATE OF BIRTH
RELATIONSHIP TO POLICYHOLDER			

Section D. Claimant Statement

DESCRIBE THE NATURE OF THE ACCIDENT AND HOW IT OCCURRED:

DATE OF ACCIDENT

1. **Was the Covered Person or Dependent treated in an emergency room or urgent care facility as a result of this accident or injury?** ..... ◯ Yes ◯ No
   If yes, please submit the emergency room discharge paperwork.
2. **Was the Covered Person or Dependent transported by an ambulance as a result of this accident or injury?** ..... ◯ Yes ◯ No
   If yes, please submit proof of the ground or air ambulance transport.

3. **As a result of the accident, is the Covered Person or Dependent deceased?** ◯ Yes ◯ No
If yes, please provide a copy of the death certificate and any other supporting documentation.

4. **Please indicate by checking "Yes" below whether the Covered Person or Dependent suffered any of the following injuries or losses as a result of the accident and please provide supporting medical documentation. Please provide a copy of the itemized statement or UB04 form from your provider.**

a. **Fracture** ◯ Yes ◯ No
If yes, please list bone(s) fractured: _____

b. **Dislocation** ◯ Yes ◯ No
If yes, please list the joint(s) where dislocation occurred: _____

c. **Burn** ◯ Yes ◯ No
If yes, please indicate severity of burn (i.e. 2nd degree, 3rd degree, etc.): _____

d. **Laceration requiring repair by stiches, sutures or staples** ◯ Yes ◯ No

e. **Eye Injury** ◯ Yes ◯ No
Eye surgery or removal of foreign object

f. **Dismemberment** ◯ Yes ◯ No
If yes, please indicate which body part was dismembered:

☐ Finger or toe ☐ Foot
☐ Eye ☐ Arm
☐ Hand ☐ Leg

g. **Travel Companion Benefit** ◯ Yes ◯ No
Lodging for Travel Companion during hospital confinement (hospital must be 50 miles from policy owner's primary address)
Number of days (up to 10 per calender year) _____
If yes, please attach lodging receipts

h. **Pet Boarding Benefit** ◯ Yes ◯ No
Boarding for one or more pets during hospital confinement
Number of days (up to 10 per calender year) _____
If yes, please attach receipts for pet boarding

Rider Benefits (if riders were purchased with this policy)
Please indicate by checking "Yes" below whether the Covered Person or Dependent suffered any of the following losses due to an injury or sickness. **Please provide a copy of the itemized statement, HCFA 1500, or UB-04 form from your provider.**

- Skilled Nursing Facility ◯ Yes ◯ No
  If yes, please list dates. From: _____ To: _____
- Hospice Care Facility ◯ Yes ◯ No
  If yes, please list dates. From: _____ To: _____
- Outpatient Surgery ◯ Yes ◯ No
  Date(s): _____
- Outpatient Diagnostic Services ◯ Yes ◯ No
  Including Outpatient Laboratory, Basic Services and Advanced Studies.
  Date(s): _____
- Wellness Benefit ◯ Yes ◯ No
  If yes, how many visits are you claiming? _____
  If yes, please list dates: _____
- Outpatient Therapy ◯ Yes ◯ No
  Date(s): _____

- Physical, Occupational or Speech Therapy ..... ◯ Yes ◯ No
  If yes, how many visits are you claiming? _____
  If yes, please list dates: _____
- Chiropractic Therapy ..... ◯ Yes ◯ No
  If yes, how many visits are you claiming?
  If yes, please list dates: _____
- New Prosthetic Device (following amputation) ..... ◯ Yes ◯ No
  If yes, please list date received: _____
- Home Modification ..... ◯ Yes ◯ No
  If yes, please list date received: _____
- Durable Medical Equipment and Appliance ..... ◯ Yes ◯ No
  If yes, please list date received: _____
- Ground Ambulance ..... ◯ Yes ◯ No
  If yes, please list date received: _____
- Air Ambulance ..... ◯ Yes ◯ No
  If yes, please list date received: _____
- Emergency Room ..... ◯ Yes ◯ No
  If yes, please list date received: _____
- Urgent Care ..... ◯ Yes ◯ No
  If yes, please list date received: _____

PART TWO

Section A. Physician Information (if you need space to list additional providers, please use attached Provider Information sheet)

Treating Physician	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	
Hospital Admission	◯ Yes ◯ No		
Treating Hospital:			
Address:	City:	State:	ZIP:
Telephone:	Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	

PART THREE

Section A. Acknowledgment

I hereby certify that the information I have provided in support of this claim is complete and true to the best of my knowledge. I have read the fraud notice, applicable to my state, included with this form. Liberty Bankers Life Insurance Company and I agree that this document may be electronically signed.

Insured's Signature: _____ Date: _____

Signature of Covered Person or Dependent Incurring Accident: _____ Date: _____

(Not required for minors under age 18)

HIPAA COMPLIANT AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Records and Information obtained will be disclosed to:

Liberty Bankers Life Insurance Company
PO Box 17628, Winston-Salem, NC 27116

The purpose of this disclosure is to evaluate claim benefits. I hereby authorize you to release any and all records and information within your possession, custody or control regarding the patient pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of the patient's physical or mental condition are to be released. Such medical and non-medical records and information to be released may include, but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKGs.

I, the undersigned, hereby authorize any and all medical practitioners, physicians and pharmacists, pharmacy benefit managers, health care clearing houses, hospitals, clinics, nurses, or records custodians to release any and all records and information regarding the patient named below. I hereby waive all provisions of law forbidding the disclosure of such information.

NAME OF PATIENT	OTHER NAMES USED BY PATIENT
PATIENT'S DATE OF BIRTH	PATIENT'S SOCIAL SECURITY NUMBER

The aforementioned medical information is to be released from: _____ and exchanged between the Insurance company first named above and:

Walker Claims Investigations, LLC
5077 Fruitville Road, Suite 109-172
Sarasota, FL 34232

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when the patient's medical and non-medical records are disclosed pursuant to this Authorization, the patient's medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. I hereby authorize any medical practitioner, physician, hospital, clinic, pharmacy benefit manager or other medical related facility, insurance support organization to provide to Liberty Bankers Life Insurance Company ("Liberty Bankers") or to any medical record retrieval services acting on Liberty Bankers' behalf. It is understood the Liberty Bankers underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such information to the aforementioned parties for purposes of this claim. This Authorization will remain in effect a maximum of six (6) months from the date of my signature below. I understand that I may revoke this Authorization at any time by requesting such of COVENTBRIDGE or Liberty Bankers in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original. I understand that if I refuse to sign this Authorization to release the patient's complete medical records, my insurance company may not be able to process my claim for benefits and may not be able to make any benefit payments or claim payments. Liberty Bankers Life Insurance Company and I agree that this document may be electronically signed.

Signature of patient/guardian personal representative:_____
(If patient is a minor, must be signed by a parent. If patient is deceased, must be signed by a spouse/legal next of kin or informant listed on the death certificate.)

Legal relationship to patient: _____

Signed this, the _____ day of _____ in the year _____

STATE FRAUD NOTICES

AK - 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.

AL – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

AR, CA, and RI – 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.

AZ – 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.

CO – 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 with 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 with the department of regulatory agencies.

DC – 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, any insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

DE – 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.

FL – 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.

ID – Any person, who knowingly and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

IN – Any 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.

KY – 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.

LA and WV - 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.

ME, TN, VA and WA: 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 denial of insurance benefits.

MD – 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.

MN - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH - Any person who, with a purpose to injure, defraud or decieve any insurance company, files a statement of claim containng any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. §638:20.

NJ - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in any application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OH – 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.

OK – 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.

PA – 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.

TX - Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

All Other States – 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.