American Fidelity Assurance Company

A member of the American Fidelity Group®

Hospital GAP PLAN®

Need to file a claim? Just follow these steps...

Base Hospital GAP PLAN®

This is for Inpatient Hospital Confinements, treatment in a Hospital Emergency Room, Outpatient Surgery in a Hospital Outpatient Facility or a Free-Standing Outpatient Surgery Center, or Diagnostic Testing in a Hospital Outpatient Facility or MRI Facility.

1. Fill out the *Statement of Insured* on the claim form (BN-665) as completely as possible.

2. Sign and date the Authorization section. The insured must sign and date the claim form for dependent children.

3. When filing the first claim, please provide documentation of continuous medical coverage for the past 12 months. This information may come from the employer or the medical plan carrier/administrator. Without this information, your expenses may be subject to a Pre-Existing investigation.

4. Attach copies of the original bills showing diagnosis, date of service, itemized charges, name and address of the provider and tax identification number (TIN).

5. Attach copies of Explanation of Benefits (EOB) from the primary insurance carrier.

Physician Outpatient Treatment Benefit

This is for treatment in a hospital outpatient clinic, free-standing emergency care clinic, or a physician's office.

1. Send copies of the original bills showing the diagnosis, date of service, itemized charges, name and address of the provider and the tax identification number. An Explanation of Benefits from the primary insurance carrier **is not needed.**

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMS, PLEASE CONTACT OUR BENEFITS DEPARTMENT BETWEEN 7:00AM TO 5:30PM CST AT 1-800-267-2322.

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American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax# (405)523-5762
Toll Free Fax # 1-888-243-3453

REQUEST FOR MEDICAL REIMBURSEMENT

INSTRUCTION TO INSURED

1. Fully complete the claim form.
2. **For claim consideration** of physician office or clinic visit, please submit the itemized bills including diagnosis to the address or fax number above.
3. For **ALL** other charges, please submit itemized bills including diagnosis and the medical carriers' Explanation of Benefit sheet(s).

WARNING: 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 may be guilty of insurance fraud and subject to criminal and civil penalties.

INSURED INFORMATION

Insured's Name:	Insured's Date of Birth:	Insured's Social Security Number:
Address:	City:	State/Zip Code:
Insured's Customer Number:	Home Telephone Number:	Work Telephone Number:

PATIENT INFORMATION

Patient's Name:	Patient's Date of Birth:	Patient's Social Security Number:

Relationship To Insured: Self ❒ Husband ❒ Wife ❒ Son ❒ Daughter ❒ Other ❒

If other was checked, please indicate relationship to insured:____________________

CLAIM INFORMATION

1. What kind of claim is this? Physician Office or Clinic Visit ❒ Outpatient Care ❒ Inpatient Care ❒
2. Claim is due to: Illness ❒ Accident ❒ Pregnancy ❒
3. If illness, date of onset:____________________ If pregnancy, date first diagnosed: ____________________

   Diagnosis/ICD9 code(s): ____________________
4. If accident, please explain how, when, and where it happened: ____________________
5. If claim is due to work related accident or sickness, please provide employer's name and phone number: ____________________

   Name: ____________________ Phone Number:____________________

MEDICAL INFORMATION RELEASE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my or my dependents' medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics, or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation carrier.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial of benefits. *I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, AWD Benefits Department, P.O. Box 268898, Oklahoma City, Oklahoma 73126-8898 or calling toll free 1-800-437-1011. I understand that my right to revoke this authorization is limited to the extent that AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.*

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first. **For Arizona residents,** release of HIV/AIDS - released information can only be disclosed for a period not to exceed 180 days from the date shown below.

Print Name:____________________Signature:____________________ Date:____________________

Please retain a copy for your personal records, or you may request a copy from our company.