

### Association Services, Inc.

Specializing in Employer Group Health & Payroll Worksite Insurance Products

### SAMPLE CLAIM LETTER

NAME
ADDRESS LINE 1
ADDRESS LINE 2

Reference to: Wellness Benefit

Enclosed is a American Public Life wellness benefit claim form. **Please complete** the form and return to:

ASI 28975 S Satsuma Road, Suite A Livingston, LA 70754

You must complete the "CLAIMANT'S STATEMENT" making sure to sign and date the bottom (page 1). You must sign and date the "AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION" (page 2). Also, you need to include a copy of the itemized billing for the wellness procedure. Please make sure all information is complete before returning! If you should have any questions, please give us a call. Thanks and have a blessed day!

Sincerely,

**Association Services Staff** 

28975 S. Satsuma Road, Suite A Livingston, LA 70754 (225) 435-0400 / 888-928-9222 Fax (225) 435-0403 www.asi-ins.com

### **Accident and Health**

# **American Public Life Insurance Company**

SIGNING BELOW I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDG	Name of Claimant		S	S#	Policy/Certificate #	
Name of Primary Insured  SS # Primary Insured's Employer  Is-this claim due to an eccident? Will a Worker's Comp claim be-filed?  Describe Illness/Injury. If injury, how did it occur?  IMPORTANT: SUBMIT A COPY OF THE POLICE REPORT IF CLAIM IS DUE TO A VEHICLE ACCIDENT.  SUBMIT A COPY OF THE PATHOLOGY REPORT IF CLAIM IS DUE TO A VEHICLE ACCIDENT.  SUBMIT A COPY OF THE PATHOLOGY REPORT IF CLAIM IS DUE TO A VEHICLE ACCIDENT.  Were you hospitalized? Where? Discovering the condition before? When?  Names and addresses of Attending Physicians (if necessary, list on separate pices of paper and attach):  Address  POR DISABILITY CLAIMS ORLY  Date you stopped working due to disability  Avarage Monthly Earnings  List job disties:  RNING A.F. For your protection Arizons law requires the following statement to appear on this form. Any person who knowingly presents a fisit desert dain for payment of a loss is subject to orimnal and obly penalties. Cap. For your protection California law requires the following of the payment of a loss is usually of a crime and may be subject to fire many person who knowingly process as false or frequency or agent of an insurance company. Penalties may include impresoment, fires, denial of insurance and olvid damages rance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to an insurance company for attempting to defraud the policyholdra result of the purpose of defrauding or attempting to defraud the policyholdra or claims with inspart to a settlement or award payable from insurances company to the purpose of defrauding or attempting to defraud the policyholdra or claims with inspart to a settlement or award payable from insurance company to the purpose of defrauding process on the purpose of the purpose of meladeing information or concests, for the purpose of misleading information is aguily or a defrauding the compa	Street Address or P	О Вох		City, State a	and Zip	
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## A member of the American Fidelity Group

PO Box 925, Jackson MS 39205-0925 • Toll Free Fax (877) 365-9423 • Toll Free Telephone (800) 256-8606

#### AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Public Life Insurance Company (APL) 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) pharmacies; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carriers. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

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. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome/AIDS Related Complex) 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. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

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 or a delay of benefits. I understand that I may revoke this authorization at any time by writing to APL South Claims Department, PO Box 925, Jackson MS 39205-0925 or by calling, toll-free, 1-800-256-8606. I understand that my right to revoke this authorization is limited to the extent that: action has been taken in reliance on the authorization; or the law provides 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 redisclosed and no longer protected by the 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.

Signature (Patient) or Personal Representative (if applicable)	Printed Name (Patient)	
Date of Birth	Date Signed	
I certify this information is true and correct.		
Relationship of Personal Representative to Patient		
If authorization is supplied by a personal representative, a descripte included.	otion of the authority to act on behalf of th	e Insured must

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

Certain products administered by American Public Life Insurance Company are underwritten by American Fidelity Assurance Company.

CLAUTH (09/09)