

HOSPITAL CONFINEMENT INDEMNITY (GAP) CLAIM FORM



FIDELITY SECURITY LIFE INSURANCE COMPANY

MAIL TO: SPECIAL INSURANCE SERVICES, INC
 PO BOX 250349
 PLANO, TX 75025-0349
 (800) 767-6811 - phone; (214) 291-1301 - fax
 Email: customerservice@specialinc.com

CHECKLIST

1. Complete STATEMENT OF INSURED below, answering all questions fully.
2. **ATTACH EXPLANATION OF BENEFITS (EOB) provided by the insurer for your Comprehensive Major Medical Plan, if applicable, to this claim form.**
3. Return this claim form, all itemized bills and EOBs to the address shown above.

STATEMENT OF INSURED

Your Name		<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Policy Number MG 108691741		Social Security Number		Phone Number	
Your Address (Number and Street)		City		State	Zip Code
Name of Patient				Date of Birth	
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter					
Does Patient have a Medicare Health Insurance Claim Number (HICN)? <input type="checkbox"/> Yes <input type="checkbox"/> No				If "Yes", please provide HICN #:	
Describe Injury or Sickness Completely (<i>If injury, describe how accident occurred</i>)					
Date of Injury or Beginning of Sickness:					
Name and Address of Physician Who First Treated This Condition					Date First Treated
Is Injury or Sickness Due to Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			Will You or Your Dependent File for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you or your dependent covered under any other insurance plan (including Blue Cross & Blue Shield), Student Accident, Hospital Indemnity or Governmental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes", please specify insurance carrier's name, address, policy number and daily benefit amount, if applicable, for any other insurance plan that you currently have, or any plan that has terminated since the effective date of your coverage under Hospital Confinement Indemnity plan.					
Name of Company	Address	Coverage Type	Policy Number	Benefit Amount	Termination Date

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he/she 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. ***NOTICE - See State Specific Fraud Notices on Next Page***

I certify that the information given by me in support of this claim is true and correct.

Insured's Signature

Date

IMPORTANT! PLEASE COMPLETE THE AUTHORIZATION INCLUDED WITH THIS FORM



c/o SPECIAL INSURANCE SERVICES, INC. • P.O. BOX 250349 • PLANO, TX 75025-0349
800-767-6811 • FAX 214-291-1301 • EMAIL customerservice@specialinc.com

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

I authorize the disclosure of health information regarding, or related to:

Name: _____ Date of Birth _____
Policy No. MG10869174 Claim No. _____

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This Authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultations, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this Authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations such as MIB, Inc. ("MIB"), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Fidelity Security Life Insurance Company, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this Authorization to administer the above referenced individual's health insurance coverage. I authorize Fidelity Security Life Insurance Company to make a brief report of my protected health information to MIB.

A photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two years from the date shown below.

I understand that my providers may not refuse to provide treatment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Fidelity Security Life Insurance Company may not be able to make any benefit payments. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64141-8131, Attention: Privacy Officer.

I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and once re-disclosed, I may no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that I will receive a signed copy of this Authorization.

Signature of the individual or the individual's personal representative

Date

If signed by the individual's personal representative (e.g. a parent on behalf of a child), describe your authority to sign on behalf of the individual