

Fidelity Life Association 877-352-3303 Option 2

Administrative Office: 17 Church Street PO Box 506 Keene, NH 03431

Employer's/Business Entity's Statement									
1. Name of Employee/Insured Person	2. Social Security No.			3. Date of Birth					
4. Phone No.	5. Group No.			6. Occupation					
7. Employee's/Insured Person's Str	8. City	9.	State	10. Z	ip Code				
11. Employer/Business Entity	12. Employe	r/Business Entity Phone No.	13. Duties						
14. Employer's/Business Entity's Stre	15. City	16.	State	ip Code					
Signed in (City/State)		This Day o	of (Mo	nth/Year)					
Name of Company		Official Position							
Name of Company Signature Official Position  Claimant's Statement									
☐ Home Health ☐ Adult Day Care									
1. Policyholder	2. Polic	cyholder's Social Security No	. 3.	3. Policy No.					
4. Patient's Name	ent's Social Security No.	6.	6. Phone No.						
7. Street Address	8. City	9.	State	10. Z	0. Zip Code				
11. Type of Residence:   Home Apartment Retirement Community Other									
12. Describe condition for which clai	im is being mad	de							
13. Name of Attending Physician	<del></del>	····							
15. Street Address	16. City		17. State		18. Zip Code				
19. Name of Hospital	20. Date Admitted		21. Date Discharged						
22. Street Address	23. City		24. State		25. Zip Code				
Name, address and telephone n	umber of pers	son assisting with claim	(if any	/)					
26. Name 27.	Relationship		28. Pł	28. Phone No.					
29. Street Address	30. (	City 31		31. State		32. Zip Code			
Attach a copy of Legal Instrument.	Check One:	□ Power of Attorney □	Guard	ianship		and the state of t			
Patient or Personal Representative's S	Signature	Γ	Date	And the second s					

					essme								
To be complete	ed by	Case Mar	ager					Regist	tered Nurse o	or Physician			
1. Patient Name 2. Date of Birth													
3. Diagnosis													
1.					2.								
_1,					4.	·							
5.					6.								
4. Was Patient Hospitalized? ☐ Ye	es 🗆	No		5. V	Vas Pa	tier	nt in a Nurs	sing Ho	me Facility?	□ Yes □	No		
From To													
_					7. Medicare Coverage  Yes  No								
From 10  8. The above listed patient requires of	are to	perform t						ina or 1	instrumental A	ctivities of Da	aily L	iving	  .
I= Independent S=Stand-by Assi	stance	at Arm's	engt	h O	=Needs	s Ha	ands-On to I	Perform			•	_	
ADL ]	S	0				IAD					I	S	0
a. Bathing				h. Medicine Admin			ļ	ļ	ļ				
b. Dressing				i. Personal Financial				ļ	-				
c. Toileting				j. Prepare/Coo						-	ļ	ļ	
d. Continence		<u> </u>		k. Use Telephone			ļ	ļ					
e. Mobility				I. Housework				-	ļ	-			
f. Transfers				m. Laundry				ļ	ļ				
g. Feeding/Eating											<u> </u>	<u> </u>	
9. Cognitive Impairment: [] Yes [] No (  10. I hereby certify that the above list								days or	more: [] Yes	[] No			
11. Patient Requires: [] Home Health	Care	[] Adult D	ау Са	re [	] Hospi	ce F	Program []	Respite	e Care [] Ass	isted Living F	acilit	У	
12. Recommended Services: [] Nurse [] Therapist [] Homemaker [] Companion [] Other													
13. Total Number of Days Per Week:  14. Number of Hours Per Day:  15. Where is care being provided? [] Home [] Apartmer Retirement Community [] Facility [] Other							nt []						
16. Name of Provider: 17. Tax ID/				ID/Social Security No.: 18. Phone No.			.:						
19. Street Address: 20.			20. City:			21. Sta	l ate:	22. Zip Code	e:				
								<u> </u>					
23. Type of License: [] Heath Care Age	ency C	are [] Adu	lt Day	/ Care	e [] Hos	spice	e Program [	] Other					
24. Print Name: 25. Do			. Deg	Degree:			26. Phone No.:						
27. Street Address: 28		8. City:			29. State:		30. Zip Code:						
Signature							Date	!					

- Attach the following documents:

  1) Plan of Care
  2) 2) Itemized Billing Statement
  3) 3) Explanation of Medicare Benefit Statements (if Medicare coverage on these services)

## REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

FOR RESIDENTS OF MARYLAND: Any person who knowingly and FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit with intent to injure, defraud, or deceive an insurance company files a or who knowingly and willfully presents false information in an application claim containing false, or misleading information may be prosecuted under for insurance is guilty of a crime and may be subject to fines and state law. confinement in prison. Claimant's signature Date Claimant's signature Date FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent FOR RESIDENTS OF ARIZONA: For your protection, Arizona to defraud or help commit a fraud against an insurer is guilty of a crime. law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent Claimant's signature Date claim for payment of a loss is subject to criminal and civil FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a penalties. purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading Claimant's signature Date information is subject to prosecution and punishment for insurance fraud, FOR RESIDENTS OF CALIFORNIA: For your protection California law as provided by RSA 638:20. requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a Claimant's signature Date crime and may be subject to fines and confinement in state prison. FOR RESIDENTS OF NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is Date Claimant's signature subject to criminal and civil penalties. FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance Claimant's signature Date company for the purpose of defrauding or attempting to defraud the FOR RESIDENTS OF OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance proceeds of an insurance policy containing any false, incomplete or company who knowingly provides false, incomplete, or misleading facts or misleading information is guilty of a felony. information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a Claimant's signature Date FOR RESIDENTS OF PUERTO RICO: Any person who knowingly and settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of with the intention of defrauding presents false information in an insurance regulatory agencies. application, or presents, helps, or causes the presentation of a fraudulent claim for the same damage or loss, shall incur a felony and, upon Claimant's signature Date conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) FOR RESIDENTS OF DELAWARE, IDAHO or INDIANA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. Claimant's signature Date Claimant's signature Date FOR RESIDENTS OF VIRGINIA, TENNESSEE, MAINE, or DISTRICT OF FOR RESIDENTS OF FLORIDA: Any person who knowingly and with COLUMBIA: It is a crime to knowingly provide false, incomplete or intent to injure, defraud, or deceive any insurer files a statement of claim misleading information to an insurance company for the purpose of or an application containing any false, incomplete, or misleading defrauding the company. Penalties include imprisonment, fines, and denial information is guilty of a felony of the third degree. of insurance benefits. Claimant's signature Date Claimant's signature Date FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss FOR RESIDENTS OF ALL OTHER STATES: Any person who knowingly, or benefit is a crime punishable by fines or imprisonment, or both. and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim Claimant's signature Date containing any materially false information or conceals for the purpose of FOR RESIDENTS OF LOUISIANA: Any person who knowingly presents a misleading, information concerning any fact material thereto commits a false or fraudulent claim for payment of a loss or benefit or knowingly fraudulent insurance act, which is a crime and subjects such person to presents false information in an application for insurance is guilty of a criminal and civil penalties. crime and may be subject to fines and confinement in prison. Claimant's signature Date Claimant's signature Date



Established 1896

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## **AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

- 1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information; the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
- Description of the information that may be used or disclosed: This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
- The information will be used or disclosed only for the following purpose(s): The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

## STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosers of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature			Date	
Patient/Insured's SSN	Patient/Insured's Date of Birth		Patient/Insured's Phone No.	
Patient/Insured's Address				
Personal Representative's (if any) Name/Signature:			Personal Representative's Phone No.	
Personal Representative's (if any) Address				
Description of Personal Representative's Authority or Relationship to Patient/Insured			-	
Policy or Contract Number				
Claimants s	hould retain a cor	by of this signed docume	ent for their records	