ATLANTIC AMERICAN
Employee Benefits

Atlantic American Employee Benefits Claims Department
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7502
Email: groupclaims@atlam.com

A Guide for Successfully Completing the Group Short-Term Disability Claim Form

Atlantic American Employee Benefits appreciates the opportunity to provide valuable income protection. We rely on the information provided on the following forms to effectively determine if you qualify for benefits.

This guide provides information and instruction to help successfully complete and submit all required forms. You may also submit the claim online for a more expedited experience. Please consult your employer/benefits administrator if you need assistance in providing information.

What You Need to File a Claim

- Claim Form
- Authorization to Release Personal Information
- Attending Physician Statement
- Proof of services (some examples below):
  - Emergency room, physician or urgent care report
  - Operative/surgical report
  - Scan/imaging report for major diagnostic imaging
  - Physician office notes
- Employer Statement
- (Optional) Authorization to Disclose Health Information to My Employer

Guidelines for Claim Form

This section is to be completed by you, the Employee. Dates should include the month, day and year. In order to be considered complete, the form must be signed by you.

- Policy Number will consist of ten digits which will come after “005”.
- Job Title is the title of your position held with the Employer.
- The Hours Worked per Week is the number of hours you worked per week for the Employer.
- Date of Disability indicates the first day on which you became unable to work because of the disabling condition.
- Date First Treated indicates the date you first sought medical care because of the disabling condition.
- Motor Vehicle Accident Report (if applicable)—If the disability was the result of an auto accident, you are required to submit a copy of the police report.

Payment Method

- If no payment method is selected, a check will be mailed.

(Continued on next page)

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to My Employer

Both authorizations are to be completed by you, the Employee. Dates should include the month, day and year. In order to be considered complete, the form must be signed by you or your legal representative.

- Medical records from your providers may be needed in order to make a determination on your claim. A completed authorization form will be needed to obtain them. To avoid any additional delays in the claim, please be sure to complete and submit the authorization forms with your claim application.
- By signing the authorizations, you are applying for short-term disability benefits and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name on any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Employer Statement

This section is to be completed by the Employer. Dates should include the month, day and year. In order to be considered complete, the form must be signed by the Employer.

- Date Covered Under This Plan indicates the date in which the Employee's coverage became effective.
- Please include copy of Employee's enrollment form, if applicable.
- For an accident or injury that occurred on the job, a copy of the workers' compensation report is required.

Guidelines for Attending Physician Statement

This section is to be completed by the Attending Physician. Dates should include the month, day and year. In order to be considered complete, the form must be signed by the Attending Physician.

Submitting Your Claim

Email/Fax:

Email: claims@atlam.com
Fax: 404-926-4036

Mail:

Attn: Claims Department
4370 Peachtree Road NE
Atlanta, Georgia 30319

Claims Questions

Phone: 866-458-7502
Email: groupclaims@atlam.com

Online Claim Submission or Claims Status

https://mycoverage.atlam.com/

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Mail To: **Atlantic American Employee Benefits**
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7502
aaemployeebenefits.com/employees

SHORT-TERM DISABILITY CLAIM FORM

Has a Claim been filed before for this loss? ..... ❒ **Yes** ❒ **No**

Section 1 – Employee Information

Current Name (First, Middle & Last)	Policy #	Job Title	Hours Worked per Week
Address	City	State	Zip

Home Telephone #	Cellular Telephone #	Employee SSN
Email Address	Date of Birth	

Section 2 – Details of Disability

Date of Disability		
Nature of disability and when symptoms first appeared or describe how and where accident occurred (including date(s) and times)		
Date First Unable to Work	Date First Treated	Estimated Return to Work Date
Was disability work-related? ❒ Yes ❒ No	Have you returned to your main duties of your occupation? ❒ Yes ❒ No	Hours worked per week (after disability)

Section 3 – List all Physicians who have treated you for this condition

Name	Street Address, City/State/Zip	Phone #
Name	Street Address, City/State/Zip	Phone #
Name	Street Address, City/State/Zip	Phone #

Have you received treatment, medication or advice from a physician in the past for this or a similar condition: ❒ Yes ❒ No
If "Yes", provide the dates, names and address of the physician:

Name	Street Address, City/State/Zip	Phone #
Name	Street Address, City/State/Zip	Phone #

Section 4 – Payment Method

Payment method:

❒ Check ❒ Electronic Funds Transfer (EFT)

For EFT, complete the following bank information

Bank Name	Bank City	Bank State	Bank Zip

Bank Account Number	Bank Routing/Transit Number	Type of Account (*check only one*)
		❒ Checking ❒ Savings

Notice regarding electronic funds transfer: When you select electronic funds transfer as your payment method, we may receive and contribute customer account and payment account data to a third party consumer reporting agency to confirm the feasibility of a transaction to your account.

Section 5 – Payment Authorization and Signature

Payment Authorization

I understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that Bankers Fidelity Life Insurance Company®, d/b/a Atlantic American Employee Benefits (hereinafter referred to as "Atlantic American"), can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid. I further understand and agree that any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that Atlantic American has no obligation to retrieve those funds or make replacement payment(s) to me. I further understand and agree for myself, my heirs, executors and estate to indemnify and hold Atlantic American harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization. I further understand and agree that Atlantic American is not responsible for any bank charges or other costs associated with or arising out of this agreement. I further understand that if my bank is not able to accept EFTs, check(s) will be mailed to my residence. I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following Atlantic American's receipt of the notice.

Dated: _____ Signed: X_____

Fraud Warnings:

Before signing this form, please see next page, STATE EXCEPTION FRAUD WARNINGS, for the state where you reside, and the state where the group policy and certificate for which you are claiming a benefit were issued.

Signed: X_____ Dated: _____

STATE EXCEPTION FRAUD WARNINGS

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties. *(Applicable for all other states.)*

Alabama Residents Only
WARNING: 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 for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska Residents Only
WARNING: 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.

Arizona Residents Only
WARNING: 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.

Arkansas Residents Only
WARNING: 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.

Colorado Resident Only
WARNING: 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 for the 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 within the department of regulatory agencies.

Delaware Residents Only
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia Residents Only
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, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida Residents Only
WARNING: 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.

Idaho Residents Only
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana Residents Only
WARNING: A 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.

Kentucky Residents Only
WARNING: 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.

Louisiana Residents Only
WARNING: 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.

Maine Residents Only
WARNING: 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 a denial of insurance benefits.

Maryland Residents Only
WARNING: 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.

Minnesota Residents Only
WARNING: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents Only
WARNING: Any person who with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey Residents Only
WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico Residents Only
WARNING: 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 civil fines and criminal penalties.

Ohio Residents Only
WARNING: 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.

Oklahoma Residents Only
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.

Oregon Residents Only
WARNING: Any person who knowingly presents a false statement in an application for insurance or statement of claim may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania Residents Only
WARNING: 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.

Rhode Island Residents Only
WARNING: 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.

Tennessee Residents Only
WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents Only
WARNING: Any person who, with the 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 may have violated state law.

Washington Residents Only
WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia Residents Only
WARNING: 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.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

Name of Claimant (Last, First, Middle)	Date of Birth	Social Security Number

2. Personal Information to be released:
   - Data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - Any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - Any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. I understand my Personal Information will be used by Bankers Fidelity Life Insurance Company, d/b/a Atlantic American Employee Benefits (hereinafter referred to as "Atlantic American"), to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Atlantic American to release my Personal Information as follows:
   - Other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - To vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - To my employer for use in discussions with Atlantic American regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - As otherwise required or permitted by law or as I further authorize

4. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

5. I understand that I may revoke this Authorization at any time by providing a written request to Atlantic American at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Atlantic American receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

Name(s) used for records (if different than the name above) _____

Signature of Claimant _____

Date _____

If Applicable

I am the Legal Representative of the person whose health information is to be disclosed, but I am authorized to grant permission on behalf of that person. If signing as Legal Representative, a copy of the executed Power of Attorney, Guardianship or other similar documents granting you the capacity to represent the insured or act on their behalf, must be submitted.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

ATLANTIC AMERICAN
Employee Benefits

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO MY EMPLOYER

I, the undersigned Insured, authorize Atlantic American Employee Benefits to disclose health information about me to my employer and to my employer's broker. I understand that this information may only be used by my employer and its broker to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use, only if they are in direct relation to the claim being audited or adjudicated.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may be significantly delayed or even denied.

This authorization will remain in effect for 24 consecutive months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Claims Department
Atlantic American Employee Benefits
4370 Peachtree Road NE
Atlanta, Georgia 30319
Email: claims@atlam.com
Or
Fax: (404) 926-4036

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Print Name and Address _____

Signature _____ Date _____

Or

If Applicable: I am the Legal Representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person. If signing as Legal Representative, a copy of the executed Power of Attorney, Guardianship or other similar documents granting you the capacity to represent the insured or act on their behalf, must be submitted. Failure to do so may result in a delay in the processing of the claim for benefits.

Printed Name of Legal Representative _____

Signature of Legal Representative _____

Type of Legal Representative _____

Date _____

RETAIN A SIGNED COPY FOR YOUR RECORDS

ATLANTIC AMERICAN
Employee Benefits

Mail To: **Atlantic American Employee Benefits**
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7502
aaemployeebenefits.com/employees

EMPLOYER STATEMENT

(Answer all questions to avoid any delays)

TO BE COMPLETED BY EMPLOYER

Company Information

Company Name			
Address	City	State	Zip
Phone #	Email Address		

Employee Information

Employee Name	Phone #		
Address	City	State	Zip
Employee's Job title	Employee's Date of Hire	Hours Worked per Week	
Gross Weekly Earnings / Was disability on the job? ❒ Yes ❒ No	Date of Disability	Date covered under STD plan	
Has employee returned to work? ❒ Yes ❒ No	If "yes", date returned to work. If "no", expected return to work date.		
Total Disability: On what date was the employee totally disabled?	Partial Disability: On what date did the employee perform only partial duties?		

Printed name and title of representative completing this form

Signature of representative completing this form

Date

*Please notify Atlantic American if the employee returns to work after the submission of this form.

(Answer all questions in order to avoid delays)

ATTENDING PHYSICIAN STATEMENT

Physician Information

Patient Name	Patient Date of Birth

1. Diagnosis(es) _____

_____

ICD-10 code(s) _____

2. How did condition(s) originate? _____

_____

_____

Date Symptoms First Appeared	Initial Date of Treatment	Last Date of Treatment	Next Date of Treatment

Is disability due to:	Is disability work-related?	Has patient ever had same or similar condition(s)?
❒ Accident/Injury ❒ Sickness	❒ Yes ❒ No	❒ Yes ❒ No

3. If applicable, list the surgical code(s)/procedure(s) – describe fully and provide date(s), if any. _____

_____

If disability is due to pregnancy, please provide the information below:

Actual Date of Pregnancy	Actual Type of Delivery
	❒ Natural ❒ Cesarian

If any of the following questions are answered "Yes", provide the information to the right of the question

Was the patient treated in an emergency room?	❒ Yes ❒ No	Date Treated	Name of Hospital
Was the patient hospital confined?	❒ Yes ❒ No	Date(s) Confined	Name of Hospital
Did patient have outpatient surgery in a hospital or ambulatory surgical center?	❒ Yes ❒ No	Date of Surgery	
Did or will another physician treat the patient?	❒ Yes ❒ No	Date Treated/Treating	Name of Physician

1. What functions of the person's own/usual occupation is the person unable to perform? _____

_____

2. What functional restrictions have been placed on this person? _____

_____

How long was or will patient be continuously **totally disabled** (unable to return to work)? From _____ To _____

How long was or will the patient be **partially disabled**? From _____ To _____

_____ _____ _____

Physician Name (Print) Physician Signature Date

_____ _____

Physician Address (Street, City/Town, State) Telephone Number