Bankers Fidelity Life Insurance Company®
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7499

A Guide for Successfully Completing the Short Term Care Claim Form

Bankers Fidelity Life Insurance Company appreciates the opportunity to provide you with valuable protection. We rely on the information you provide on this form to effectively determine if you qualify for benefits.

This guide provides information and instructions to help you successfully complete and submit the claim form.

What You Need to File a Claim

- Claim Form
  - Copy of Power of Attorney Papers (if applicable)
- Authorization to Obtain and Disclose Information (HIPAA form)
- Attending Physician Statement
- Proof of services (some examples below):
  - UB04 (itemized hospital bill) showing room and board
  - Daily nursing notes from the nursing facility

Forms to be completed by the Nursing facility administrator

- Nursing Facility Claim Form-
  - Provide a copy of:
    - Nursing facility license
    - Facility administrator license
- Leave of absence form

Authorization to Disclose Personal Information

This authorization 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 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.
- 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 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: claims@bflic.com

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

Claims Questions

Phone: 866-458-7499
Email: claimsservices@bflic.com

Bankers Fidelity®

Short-Term Care Nursing Facility Claim Form

Administered By:
Bankers Fidelity Life Insurance Company
4370 Peachtree Road NE
Atlanta, Georgia 30319
1-800-241-1439

Claims Department
4370 Peachtree Road NE
Atlanta, Georgia 30319
866-458-7499

TO BE COMPLETED BY THE POLICYHOLDER

PATIENT INFORMATION

Name	Date of Birth (MONTH / DAY / YEAR)	Gender	Policy Number
		❑ Male ❑ Female	

Address (Street/City/State/Zip)	Telephone Number	Social Security Number

1. Where are you currently residing:

❑ Private Home/Home Health Care
❑ Hospital
❑ Independent Living Unit/Retirement Facility
❑ Nursing Care Facility (Nursing Home)
❑ Assisted Living/Personal Care
❑ Other, Specify: _____

2. Person to Contact if you cannot be reached:

Name: _____ Telephone No. _____
Address _____

_____

3. Name of Primary Caregiver: _____

Relationship: ❑ Spouse ❑ Child ❑ Sibling ❑ Other Relative, Specify: _____
❑ Friend ❑ Home Health Care Agency ❑ Roommate/Companion
❑ Neighbor ❑ Other, Specify: _____

4. Describe your current condition and its cause:

5. Which of the following Activities of Daily Living do you need assistance with?

ADL	Dates on which you first received assistance (Month/Day/Year)
❑ Bathing/Toileting.....	_____
❑ Dressing.....	_____
❑ Transferring.....	_____
❑ Continence	_____
❑ Eating	_____

6a. Date first saw a doctor for this condition. _____ Were you hospitalized? ..... ❑ Yes ❑ No

b. If "Yes," name and address of facility.

_____

Date Admitted:_____ Date Discharged: _____

7. Name and address of treating physician(s) or practitioner(s):

Name & Address	Telephone Number	Most Recent Date Consulted
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Power of Attorney information (If available)
Power of Attorney - First and last name: _____
Effectiv date for Power of Attorney: _____
Addresss _____ City:_____ State: _____ Zip Code: _____

PLEASE ENCLOSE A COPY OF ANY POWER OF ATTORNEY, GUARDIANSHIP, OR TRUSTEE PAPERS WITH THIS CLAIM FORM

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.

FL. Residents Only: 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. **MD Residents Only:** 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 may be guilty of insurance fraud as determined by a court of competent jurisdiction. **PA Residents Only:** 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. **VA Residents Only:** 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. **WA Residents Only:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Claimant Signature _____

Bankers Fidelity®

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By signing below, you acknowledge and consent to the use of your Personal Health Information (PHI) by Bankers Fidelity Life Insurance Company and its subsidiaries, affiliates, and related companies (collectively referred to as "Bankers Fidelity"), for the purpose of evaluating claim benefits and payments. If you choose not to sign this Authorization, your claim for benefits may not be processed. You also authorize Bankers Fidelity to release your Personal Information as follows:

- Any and all medical practitioners, physicians, nurses, pharmacist, hospitals, clinics, long-term care, facilities, medical or medical-related facilities, laboratories, insurance, companies, and insurance support organizations, records, custodians, or anyone else with knowledge of me or my health.

I, the undersigned, authorize any covered entity or business associate to the use and/or disclose of Personal Health Information of:

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

Personal Health 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). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

The Personal Health Information to be released is requested for the following reason(s):

This protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite Insured's application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage Insured has or has applied for with Bankers Fidelity.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to Bankers Fidelity at 4370 Peachtree Road NE, Atlanta, GA 30319. **If written revocation is not received, this authorization will remain valid until 24 months after the date signed**. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I am entitled to receive a copy of this authorization. A photographic copy of this authorization is as valid as the original. I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

Insured's Signature	Date

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	Date

THIS FORM IS FOR USE WHEN AUTHORIZATION IS REQUIRED AND COMPLIES WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY STANDARDS.

Short-Term Care
Attending Physician Statement

Administered By:
Bankers Fidelity Life Insurance Company
4370 Peachtree Road NE
Atlanta, Georgia 30319
866-458-7499

Submit form to:
Mail: 4370 Peachtree Road NE
Atlanta, GA 30319
Email: Claims@bflic.com

Patient Name	Date of Birth MONTH | DAY | YEAR	Gender ❑ Male ❑ Female

1. Current Patient Location:

❑ Private Home/Home Health Care ❑ Nursing Facility ❑ Hospital
❑ Custodial Care Facility ❑ Retirement Facility/Independent Living Unit ❑ Assisted Living
❑ Continuous Care ❑ Other, Specify: _____

If Currently in a facility: Admission Date: _____ Probable Discharge Date: _____

2. Provide Diagnosis (es):

_____

ICD Code: _____ Date Diagnosed: _____ Recurring Condition? ..... ❑ Yes ❑ No

3. Other conditions requiring care:

ICD Code(s): _____ Date Diagnosed: _____ Recurring Condition? ..... ❑ Yes ❑ No

4. Has patient been confined in a hospital or nursing facility within the past 5 years? ..... ❑ Yes ❑ No
If "Yes," when and where:
Name: _____
Address: _____
Confinement Dates: From _____ To _____ Reason for confinement? _____

5. Is dependency in functional status due to organic mental impairment (i.e., Alzheimer's Disease or related disorder(s))? ..... ❑ Yes ❑ No
If "Yes," give evidence of rationale used in making diagnosis (i.e., history, physical exam, diagnostic testing, mental status exam, evidence from previous treatment).

6. **GIVE THE CURRENT LEVEL OF PATIENT'S FUNCTIONING. ALSO SPECIFY THE DATE OF THIS LEVEL OF FUNCTIONING BEGAN. INDICATE APPROPRIATE NUMBER OF LEVEL.**

BATHING/TOILETING

LEVEL

1. Independent-may use assistive devices (e.g., commode, grab bars); requires no human assistance.
2. May require human assistance on an intermittent basis or with minor parts of bathing/toileting.
3. Is unable to bathe/toilet without substantial assistance from another person.

LEVEL _____ Date: _____

DRESSING

LEVEL

1. Independent-requires no human assistance.
2. May require human assistance on an intermittent basis or with minor parts of dressing.
3. Is unable to dress without substantial assistance from another person.

LEVEL _____ Date: _____

CONTINENCE

LEVEL

1. Independent-requires no human assistance or supervision; controls urination and bowel movement completely by self; may use assisted equipment (e.g.; bedpan).
2. May require human assistance on an intermittent basis for occasional "accidents." _____
3. Requires constant supervision and substantial assistance from another person with bowel and bladder control including appliances (e.g., colostomy, urinary catheter).
4. Incontinent of bowel and bladder.

LEVEL _____ Date: _____

TRANSFERRING

LEVEL

1. Independent-may use assistive device (e.g., trapeze, railings, walker).
2. Requires physical support on an intermittent basis for difficult maneuvers only (e.g., toilet, sofa).
3. Is unable to transfer without substantial assistance from another person.

LEVEL _____ Date: _____

EATING

LEVEL

1. Independent-requires no human assistance.
2. May require human assistance on an intermittent basis or with minor parts of eating. (e.g., cutting foods).
3. Is unable to eat without substantial assistance from another person.

LEVEL _____ Date: _____

Attending Physician Signature	Print Name	Degree	Date

Street Address	City or Town	State	Zip Code

Telephone	Tax ID Number

Bankers Fidelity®

Mail To: **Bankers Fidelity Life Insurance Company®**
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7499
Email: claims@bflic.com

NURSING FACILITY OR HOME HEALTH CARE CLAIM FORM

TO BE COMPLETED BY THE NURSING CARE FACILITY ADMINISTRATOR OR DIRECTOR OF NURSING

Patient Name:	Date of Birth:	Gender: ❑ Male ❑ Female	Social Security Number:	Policy Number:
Name of Nursing Care Facility:			Phone Number:	
Facility Address (Street, City, State, Zip Code):				

Is the Nursing Care Facility licensed by the state as (check all that apply):

❑ Skilled Nursing Facility ❑ Intermediate Care Facility ❑ Custodial Care Facility ❑ Assisted Living Facility
❑ Alzheimer's Treatment ❑ Personal Care ❑ Congregate Care Facility ❑ Independent Living
❑ Continuing Care Retirement ❑ Multiple Care Retirement Facility ❑ Other (Specify) _____

Does the patient have the capacity to make informed decisions? ❑ Yes ❑ No

If "No," give name, address and phone number and relationship to patient of person handling financial affairs.

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Date Admitted: _____ Date Discharged: _____
mm/dd/yy

Provide date of any previous confinements _____

Admitting Diagnosis: _____ ICD Code: _____ Date Diagnosed: _____

Secondary Diagnosis: _____ ICD Code: _____ Date Diagnosed: _____

Name of Primary Physician: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Which of the following activities of daily living does the patient need assistance. Please indicate date first needed assistance?

❑ Bathing/Toileting Date: _____ ❑ Continence Date: _____
❑ Dressing Date: _____ ❑ Eating Date: _____
❑ Transferring Date: _____

_____ _____ _____
Attending Physician Name Signature Print Name Date

_____ _____
Street Address (Street, City/Town, State, Zip Code) Telephone Number

Bankers Fidelity®

Mail To: **Bankers Fidelity Life Insurance Company®**
4370 Peachtree Road NE, Atlanta, Georgia 30319
Phone: (866) 458-7499
Email: claims@bflic.com

LEAVE OF ABSENCE FORM FOR NURSING HOME BENEFITS

TO BE COMPLETED BY THE NURSING CARE FACILITY ADMINISTRATOR OR DIRECTOR OF NURSING

Insured Name	Policy Number
This is in reference to monthly nursing home benefits. e require submission of daily nursing home notes, nursing home room and board bill, and LOA (leave of absence) form as proof of confinement. This LOA form must be completed, signed and dated by the nursing home facility.	
Name of Facility	Phone Number
Has the physician given permission to leave the facility at any time during this admission? ❑ Yes ❑ No If "yes", are overnight stays approved? ❑ Yes ❑ No	
Please list dates of any leave of absence below, circling partial, overnight, or hospital stay: From _____ to _____ Partial/Overnight/Hospital From _____ to _____ Partial/Overnight/Hospital From _____ to _____ Partial/Overnight/Hospital	

I certify that the patient received care from _____ to _____

_____	_____	_____
Date	Signature	Title

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Medical Information Request Form

INSURED NAME (First, Middle & Last)	**POLICY/CERTIFICATE NUMBER**

Please provide the names, complete addresses and telephone numbers of all physicians, hospitals and pharmacies who have treated or dispensed medication to the insured within the last 5 years in the area below.

1. PRIMARY CARE PHYSICIAN	Telephone Number
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____
2. PHARMACY NAME	Telephone Number
Street Address	
(City, State & Zip Code)	
3. HOSPITAL/CLINIC	Telephone Number
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____
4. NURSING HOME	Telephone Number
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____

5. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

1. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
2. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
3. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
4. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
5. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

*If additional space is required please use a separate sheet of paper. The more complete the information the quicker we will be able to conclude our review.