



Bankers Fidelity Life Insurance Company®

4370 Peachtree Road NE, Atlanta, Georgia 30319

Phone: (866) 458-7499

Life Waiver of Premium Guidelines

A waiver of premium claim should be filed for an insured who has been continuously disabled for the length of time indicated in the policy. Premiums must continue to be paid during the waiver elimination period.

Note: Proof of disability must be received within one year of the start of the disability.

Guidelines for Claim Form

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

- Policy number will consist of ten characters 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 is the first day you were absent from work because of the disabling condition.
- Date First Treated is the date you first sought medical care because of the disabling condition.

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.

Guidelines for Employer's Statement

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

- For an accident or injury related to on the job, a copy of the workers' compensation report is required.

Guidelines for Attending Physician's Statement

- This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.
- The insured is responsible for any costs associated with completion of the attending physician statement.

Submitting Your Claim

Email: claims@bflic.com

Mail: Bankers Fidelity Life Insurance Company
Attn: Claims Department
4370 Peachtree Road NE
Atlanta, Georgia 30319

Claims Questions

Phone: (866) 458-7499

Email: Ancillaryclaims@bflic.com



Mail To: **Bankers Fidelity Life Insurance Company**[®]
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**LIFE WAIVER OF
PREMIUM CLAIM FORM**

| | |
|--|------------------------------|
| Policyholder Information - to be completed by the insured | |
| Name (First, Middle & Last) | |
| Date of Birth | Social Security Number |
| Address (Address, City, State, Zip) | |
| Phone Number | Email |
| Specify the nature of the disability (if accident, include how, when and where accident occurred) | |
| Sickness | Date symptoms first appeared |
| Accident | Date of Accident |
| Provide your occupation | |
| From what date do you claim that the total disability has prevented you from performing <u>your own</u> occupation | |
| From what date do you claim that the total disability has prevented you from performing <u>any</u> occupation | |
| If now totally disabled, when do you expect to be able to return to work | |



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EMPLOYER STATEMENT

(Answer all questions to avoid any delays)

| TO BE COMPLETED BY EMPLOYER | | | |
|--|--|--|-----------------------------|
| Company Information | | | |
| Company Name | | | |
| Address | City | State | Zip |
| Phone Number | Email Address | | |
| Employee Information | | | |
| Employee Name | | Phone Number | |
| Address | City | State | Zip |
| Employee's Job title | | Employees Date of Hire | Hrs/per week |
| Gross Weekly Earnings | Was disability on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Disability | Date covered under STD plan |
| Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If "yes", date returned to work. If "no", list expected return to work date. | |
| Total Disability: What date was the employee totally disabled? | | Partial Disability: 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 Bankers Fidelity Life Insurance Company 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 |
| Patient disabled <input type="checkbox"/> Own Occupation <input type="checkbox"/> Any Occupation | | | |
| Patient permanently disabled <input type="checkbox"/> Own Occupation <input type="checkbox"/> Any Occupation | | | |
| 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 _____ | | | |
| Full Time <input type="checkbox"/> Yes <input type="checkbox"/> No | Part Time <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, number of hours per day _____ Week _____ | | |
| Did or will another physician treat the patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____ _____ | | | |

Physician Name (Print)

Physician Signature

Date

Physician Address (Street, City/Town, State)

Telephone Number



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Medical Information Request Form

| | | | |
|---|--|--|-------------------|
| INSURED NAME | | POLICY/CERTIFICATE NUMBER | |
| (First, Middle & Last) | | | |
| 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.