VB Accident Claim Form

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as "We" or "ManhattanLife."

Accident Insurance products insured by ManhattanLife Assurance Company of America, Manhattan Life Insurance Company.

Is the claim for the: ☐ Subscriber ☐ Dependent

If your accident plan includes the disability rider and you are filing for disability benefits, a **Disability Claim form must also be completed**

Policy Holder's Name_____Policy No._____
Date of Birth _____/_____/_____ Address_____
City_____ State _____ ZIP Code_____
Phone No. (____)_____

Patient Name_____Date of Birth_____/_____/_____
Occupation_____

Date of Accident_____/_____/_____Time of Accident _____(circle) AM PM

First date of treatment for injury_____/_____/_____

Was this accident caused or contributed to by a medical condition? ☐ Yes ☐ No

If yes, what is the medication condition? _____

Did this accident occur at work? ☐ Yes ☐ No If yes, did you inform your employer? ☐ Yes ☐ No

Have you or do you intend to file a Workers' Compensation or Occupational Disease Law Claim? ☐ Yes ☐ No

Please provide **specific** details of how your accident occurred to aid in the processing of your claim
Where did the accident occur:_____
Details on how the accident/injury occurred and type of injury:

_____
_____
_____
_____

- Was this a motor vehicle accident? ☐ No ☐ Yes (If yes, please submit a copy of the police report)
- Was the patient tested for alcohol and/or drugs? ☐ No ☐ Yes (If yes, please submit the blood alcohol report or drug screening)
- Did the accident result in the patient's death? ☐ No ☐ Yes (If yes, please submit the certified death certificate)
- Was the patient treated by a physician or in a hospital as a result of this injury? ☐ No ☐ Yes
  (If yes, submit the UB04 itemized hospital bill or HCFA1500 itemized physician bill)

Any Person, who with the 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 may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on pages 4-5)

The above statements are true to the best of my knowledge and belief.

_____ _____/_____/_____

Signature of Subscriber ***Date***

ManhattanLife.

Mail to:
ManhattanLife
VB Claims
PO Box 926169
Houston, TX 77092

Customer Service: 1-855-448-6982
Or Fax to: 1-502-405-7107
Email to: vbclaimssubmissions@manhattanlife.com

Authorization to release information - For the Use and Disclosure of Protected Health Information

Patient's Name _____ Contract No. _____

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals to disclose my protected health information to ManhattanLife Insurance Company.
3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records,client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
5. I authorize only designated staff of ManhattanLife Insurance Company, to receive, in writing, by photocopy, facimile or by telephone, my protected health information.
6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Insurance CompanyThis revocation shall become effective on the date it is received by ManhattanLife Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

I certify that I have received a copy of this Authorization and authorize the use and/or disclosure of my protected health information as contemplated herein for ☐ all records or ☐ records for dates of service _____ to _____

_____ _____ _____/_____/_____

Signature *Printed Name* *Date*

I have legal authority* under the laws of the State of_____ to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

_____ _____ _____/_____/_____

Name of Authorized Representative/Parent or Guardian *Relationship to Applicant* *Date*

** A copy of the legal authority document must be on file with ManhattanLife.*

VB Accident Claim Form

Travel Expense Rider

Please check the type of travel benefit you are claiming:

☐ Meals ☐ Use of Personal Vehicle ☐ Lodging ☐ Expenses for Common Carriers of Transportations

Please check who accompanied you for your accident treatments:

☐ Attended Alone ☐ Spouse or Friend ☐ Multiple Adults

Please include travel receipts for reimbursement of benefit.

- **Before mailling your claim form, please be sure you have included all items listed above to prevent delay in processing your claim.**
- **Attach an itemized billing from your provider that includes the dates of service, charge amount, diagnosis, and procedure codes. UBO4 & HCFA 1500**
- **Retain a copy of all information submitted for your records.**

State Specific Fraud Warning Statements

ManhattanLife:

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:

Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

Alabama:

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.

Arkansas, Louisiana, Rhode Island:

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.

Arizona:

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.

California:

For your protection California law requires the following statement to appear on this form: Any person who knowingly presents 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.

Colorado:

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

District of Columbia:

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:

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.

Kentucky, Pennsylvania:

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.

State Specific Fraud Warning Statements

Kansas:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maryland:

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.

New Jersey:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York:

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 fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Virginia:

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 the state law.