American Health and Life Insurance Company

P.O. Box 2548, Fort Worth, TX 76113-2548
Toll Free 844-859-5323 I Fax 800-350-9582
claims@MemberLifeEvents.com

LIFE EVENT CLAIM FORM
ACCIDENTAL DEATH

Member's Name:

Member's Number:

Claim Number:

LIFE EVENT - IMPORTANT INFORMATION

For Arizona residents only: For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For California residents only: For your protection California law requires the following to appear on this form. 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.

For Pennsylvania residents only: Any person who, with intent to defraud, knowingly submits an application to or files a claim with an insurance company or other person containing false, incomplete, misleading or deceptive facts, statements or information may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that can include fines and confinement in prison.

For New York 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 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.

Signature Date

For residents of other states (NOTE: None of these notices apply to Oregon residents.): Any person who, with intent to defraud, knowingly submits an application to or files a claim with an insurance company or other person containing false, incomplete, misleading or deceptive facts, statements or information or any insurance representative doing so to a policyholder or claimant with regard to a settlement or award payable from proceeds may be reported to the department of regulatory agencies and may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that include fines and confinement in prison.

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AUTHORIZATION
(Electronic signature not accepted)

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, 45 CFR § 164.508, I hereby authorize any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Railroad Retirement Board, Veterans Administration or any other organization or person having any records, data, or information concerning this claim to furnish such record, data, or information to: American Health and Life Insurance Company for the administration of its policies, for purposes of processing this claim.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may include treatment for physicial and mental illness (except for psychotherapy notes which must be requested by separate authorization), alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment.

Initials _____

This authorization shall be valid for the duration of the claim. I have the right to revoke this authorization by providing a signed and dated, written notice to the insurance company above. Once this authorization is revoked, protected health information subject to this authorization will not be used or disclosed except to the extent that this authorization has already been relied upon. I understand that in executing this authorization then information disclosed may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance and Portability and Accountability Act (HIPAA). I understand that I have the right to retain a copy of this authorization and to inspect and receive any information disclosed under its terms. A photocopy of this authorization shall be considered as effective and valid as the original.

Printed name Relationship to Member

Signature Date

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INSTRUCTIONS FOR CLAIM SUBMISSION (Print or Type)

(1) Fully complete Section A, B, Authorization, and signature fields on form (electronic signature not accepted on Authorization).
(2) Attach a certified copy of Death Certificate.
(3) All dates must include the month, day, and year (mm/dd/yy).
(4) Send this fully completed claim form and attachments to Insurance Claims Department, as indicated above, or upload your claim documents at www.MemberLifeEvents.com. Keep a copy for your records. Please be advised that email is not considered a secure method of delivery for personal/medical information. Please note, not all event types are included in all membership plans.
(5) Claim processing may be delayed if all required documentation is not provided.

Note: Altered Forms cannot be accepted.

SECTION A MEMBER'S INFORMATION

Member's Name			Social Security Number
Mailing Address	City	State	Zip
Email Address			Telephone Number

SECTION B PROVIDE THE FOLLOWING INFORMATION REGARDING THE PERSON EXPERIENCING THE LIFE EVENT

Name of deceased	Is deceased the ○ Member or ○ Member's Spouse
If claim is for Member's spouse, spouse's Social Security number	
Date of accident	Date of death
Name of deceased's primary physician, mailing address, telephone number	
Name of hospital/medical facility utilized, mailing address, telephone number	

I affirm the information I have provided herein is accurate and complete.

Signature of Member/Member's Representative Date