LifeMap® | P.O. Box 1271, M/S E8L
Portland, OR 97207

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free 1 (800) 286-1129
Fax (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Statement of Accident

Claim Filing Instructions

This Statement of Accident includes the forms required to apply for Voluntary Accident benefits. Please read this instructions carefully before submitting to LifeMap.

Have you…

1) Completed the **Insured's Statement**?
   a) Incomplete, unsigned, or undated statements will delay your claim
2) Signed and dated the **Authorization for Release of Information**?
3) Had your Employer complete, sign and date the **Employer's Statement**?
   a) The Employer's Statement must be returned to you upon completion
4) Had the physician treating you sign and date the **Attending Physician's Statement**?
   a) The Attending Physician's Statement must be returned to you upon completion
5) Attached copies of all **itemized bills*** (not EOBs) related to this accident?
   a) Bills must include date(s) of services, diagnosis code(s), procedure code(s) and change(s)
6) Included a copy of any **motor vehicle incident/accident** and/or **police report**?

*If the medical bills do **not** include all the requested information, please submit a complete copy of the patient's medical records with your claim. Additional medical information may be requested to evaluate your claim.

For Oregon Accident Policies, please note: Effective January 1, 2014, in compliance with Oregon state law, benefits for covered ambulance transportation will be paid directly to the provider of the ambulance transportation.

You are responsible for ensuring all forms are completed and returned to our office. Our review of your claim will not begin until we receive all sections completed.

Forms can be sent to LifeMap via:

Email: **claims@lifemapco.com**

Fax: **(855) 733-4615**

Regular Mail: **LifeMap Assurance Company**
Attn: Life and Disability Claims Department
PO Box 1271, M/S E8L
Portland, OR 97207-1271

You are responsible for ensuring all forms are completed and returned to our office along with the required documentation. **If a form is received incomplete, unsigned or undated, it will be returned to you for completion, delaying the claim.**

If you have any questions, please call the LifeMap Life and Disability Claims Department at 1 (800) 286-1129.

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Statement of Accident

Insured's Statement

Information about Patient

Name of Patient (Last, First, Middle Initial) ○ Member ○ Spouse ○ Domestic Partner ○ Dependent Child	Date of Birth	Patient's Social Security Number	○ Male ○ Female
Mailing Address Street & Number City State Zip			Primary Phone Number ( )

Information about Employee/Primary Insured

Name of Member, if not the patient (Last, First, Middle Initial)		Date of Birth	Social Security Number
Mailing Address Street & Number City State Zip			○ Male ○ Female
Home Phone Number ( )	Cell Phone Number ( )	Employer/Association	Policy Number

Information regarding the Accident

Date of Accident	Time of Accident ○ AM ○ PM	Location of Accident

Please describe in detail the events leading up to the accident and how the accident happened. If you need more space, please attach a separate sheet of paper. If the accident involved a motor vehicle, attach a copy of the incident/accident/traffic report.

Dates unable to work due to this accident (if applicable):
From: Through:

Is the accident the result of any of the following? (please check all that apply)

☐ Participation in a felony	☐ Bacterial infection	☐ Illegal or fraudulent work or employment
☐ Intentionally self-inflicted injuries	☐ Participation in war	☐ Commission of a crime
☐ Parachuting, bungee jumping, hang gliding, motor vehicle race or contest	☐ Service in the armed forces of any country	☐ Operating or riding in any kind of aircraft
☐ Being intoxicated or under the influence of any narcotic	☐ Participation in a riot	☐ A work-related accident
		☐ Illness
		☐ None of the above

Information about Physicians and/or Hospital

Full name of treating physician		Specialty
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )
Full name of primary physician		Specialty
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )
Full name of referring physician/hospital		
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

▶ _____ ▶ _____
Employee's Signature Date

Please complete page 4.

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California Residents: For your protection California law requires the following 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 Residents: 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 Residents: W ARNING: 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: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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

New York Residents: 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 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.

Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist, or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files, more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment for 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.

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Alaska, Kansas and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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Authorization to Obtain and Release Information

I authorize persons or entities having any records or knowledge of me or my health, including any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer:

To give Medical information including chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results and prognosis with respect to any physical or mental condition and/or treatment of me, excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records which may have been acquired in the course of examination or treatment.

If the information to be disclosed contains any of the types or information listed below, additional laws relating to the use and disclosure may apply. I understand and agree that this information will be used or disclosed only if I place my initials in the applicable space next to the type of information:

_____ Drugs/Alcohol diagnosis, treatment or referral information
_____ Mental Health information – including provider notes
_____ HIV/AIDS information
_____ Genetic Testing Information

To LifeMap Assurance Company (LifeMap) and to its authorized representatives.

- I understand that the information obtained by use of this authorization will be used by LifeMap and authorized representatives to evaluate and adjudicate my current claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing LifeMap solely to assist with the evaluation and adjudication of my current claim.
- I understand that LifeMap complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to LifeMap may be subject to redisclosure and may no longer be protected under the Health Information Portability and Accountability Act (HIPAA).
- I understand that I have the right to revoke this authorization by notifying LifeMap in writing, of my revocation. However, such revocation is not effective to the extent that LifeMap has relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that m y revocation of, or my failure to sign this authorization may impair the ability of LifeMap to evaluate m y current claim and as a result may be a basis for denying that current claim for benefits.
- I acknowledge that I have read this authorization. I understand and agree that this authorization shall remain in force for the duration of my claim(s) or 12 months, whichever occurs first. A photocopy or facsimile of this authorization is as valid as the original. I understand that I, or my authorized representative, have the right to request and receive a copy of this authorization and the information to which it pertains.

▶ _____ ▶ _____
Patient's Full Name (please print clearly) Date Signed

▶ _____ ▶ _____
Patient's Signature (or Parent/Guardian) Relation to Patient

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Statement of Accident

Attending Physician's Statement

This statement must be filled-in completely by a physician without expense to the insurance company.

Patient Information

Name of Patient (Last, First, Middle Initial)	Social Security Number	Date of Birth
Name of Primary Insured, if not the Patient	Social Security Number	Employer Name

Information about Diagnosis

Diagnosis		ICD Code(s)
Date of Accident	Time of Accident	Location of Accident

Dates of Treatment:

Dates patient was unable to work due to this accident (if applicable):
From: Through:

Is this condition due to immediate physical damage to the body which…

Results directly from an unexpected and unintentional event?	Is independent of disease, bodily infirmity or any other cause?
○ Yes ○ No	○ Yes ○ No
For fracture(s) or dislocation(s), please indicate: ○ Closed Reduction ○ Open Reduction ○ None	For lacerations, please indicate the length (in inches):
For surgical procedures, indicate: ☐ Inpatient ☐ Outpatient The type of surgical procedure(s) and date(s) performed:	For burns, indicate the degree: ☐ First ☐ Second ☐ Third Indicate total square inches of body surface burned:

Please describe in detail the events leading up to the accident and how the accident happened. If you need more space, please attach a separate sheet of paper.

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Attending Physician's Statement (continued)

Is the accident the result of any of the following? (please check all that apply)

☐ Participation in a felony	☐ Bacterial infection	☐ Illegal or fraudulent work or employment
☐ Intentionally self-inflicted injuries	☐ Participation in war	☐ Commission of a crime
☐ Parachuting, bungee jumping, hang gliding, motor vehicle race or contest	☐ Service in the armed forces of any country	☐ Operating or riding in any kind of aircraft
☐ Being intoxicated or under the influence of any narcotic	☐ Participation in a riot	☐ A work-related accident
		☐ Illness
		☐ None of the above

Information about Hospital, Intensive Care Unit or Rehabilitation Unit Confinement

☐ Hospital ☐ Intensive Care ☐ Unit Rehabilitation	Admission Date and Time:	Discharge Date and Time:
Hospital or Facility Name		Phone Number ( )
Mailing Address (street, city, state, zip)		Fax Number ( )

Information about Physician

Physician's Name (Please Print)	Degree/Specialty	Phone Number ( )
Office Address City State Zip		Fax Number ( )

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 7 of this form.

▶ _____ ▶ _____

Attending Physician's Signature Date

Please return completed form to your patient.

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New York Residents: 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 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.

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Statement of Accident

Employer's or Administrator's Statement

Information about Employee

Employee Name (Last, First, Middle Initial)	Job Title	Social Security Number	Class

Date Employed:	Date Employee Last Worked Before the Accident:	Date of Termination: ☐ N/A

Reason for stopping work: ☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired
☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ Other Reason _____

Date returned to work: Full-time: Part-time:	If part-time, number of hours worked per week:	If employee has not returned to work, estimated return to work date:

Regularly scheduled hours per week:	Please indicate which days of the week this employee is normally scheduled to work. (check) Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Please describe primary job duties:

Employee's Earnings: $		Was the Accident due to employment? ☐ Yes ☐ No ☐ Unsure
Earnings prior to increase $	Date of last increase:	
☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ shift differential ☐ bonuses ☐ other:		Has Workers' Compensation claim been filed? ☐ Yes ☐ No ☐ Not yet

If Workers' Compensation claim has been filed, was it: ☐ Approved ☐ Denied ☐ Pending

Information about Employee's Accident Insurance Coverage

Employee's Voluntary Accident coverage: Effective Date: Termination Date:	**Dependent's** Voluntary Accident Coverage: Effective Date: Termination Date:

Additional Documentation (Please attach a copy of the following documents to this form.)

- The employee's Workers' Compensation claim(s) and Approval/Denial Notification, if applicable

Information about Employer

Employer Name	Location Code (if applicable)	Group Policy Number

Employer Mailing Address Street & Number City State Zip	Phone Number ( )

Name and title of employer representative completing this form	Email Address

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 9 of this form.

▶ _____ ▶ _____
Employer Representative's Signature Date

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