Important Instructions For Completion of Claim Filings

Although this is a challenging time, We ask that you adhere to these important instructions to ensure that the proper claim form and all relevant information is submitted in a timely manner, so that We may provide you with prompt & efficient service.

Each Section of the Claim Form MUST Be Signed & Dated by the Appropriate Party for that Section.

Section I – POLICYHOLDER'S STATEMENT

- When Filing an **Accident Claim**, we may ask that the Policyholder provide relevant information necessary for the adjudication of the claim, including, but not limited to, a Police Report, Toxicology Report, Trip Itinerary/Employer Logs.
- When Filing a **Death Claim**, we will require the following:
  - Certified copy of the Original Death Certificate
  - Proof of Eligibility, Participation Validation, or Employment Verification
  - Proof of Beneficiary designation, clear copy of each beneficiary's ID, and their contact information
  - Any funeral assignments if applicable

Section II – CLAIMANT'S INFORMATION

- Unless otherwise directed, **Accident** & **Disability** Claim Benefits will be remitted directly to the Insured Party.
- When Filing an **Accident Claim**, it is the responsibility of the Claimant to remit all itemized Medical Bills for reimbursement (balance-due statements are not sufficient for reimbursement of medical expenses). We may also ask for additional information, depending on the circumstances of the accident or nature of the disability/illness.

Section III – ATTENDING PHYSICIAN'S STATEMENT

- When Filing an **Accident Claim**, the Attending Physician treating the patient for which he/she is claiming the loss must complete all applicable sections and sign in the appropriate place before submission.
- Additional Medical Records or a Physician Statement may be required in order to establish complete Proof of Loss or to maintain adjudication of disability benefits.

Section IV – BENEFICIARY INFORMATION

- When Filing a **Death Claim**, please complete & sign this Section as the Beneficiary of the Life Insurance Policy.
- Please submit, to Us, a clear & legible copy of your personal ID, such as a driver's license, along with the Claim Form.

Important Notes & Complete HIPAA Authorization – FOR ALL CLAIMS

- Written **Notice of Claim** must be submitted to Us within [20-90] Days after the date of the covered loss under the Policy, or as soon as reasonably possible.
- The appropriate **Claim Type**, pertaining to the claim being filed, must be completed and signed by all parties, as designated within the claim form, and returned to [PALIG] within [90 Days] of the Date of the Accident in order for us to determine sufficient "Proof of Loss."
- When Filing an **Accident Claim**, where the policy is an ***EXCESS PLAN***, we must receive ALL Payment Statements related to the Covered Accident, from any and all other Plans *prior to* issuing Benefit Reimbursement. This includes, but is not limited to, payment statements from primary medical insurance coverage (including major medical), automobile insurance coverage, worker's compensation, employee benefit plans, or other government plans.
- A **Claim Form** may be secured by one of the following means:
  - All claim forms may be downloaded from the Group or Member Web Portal at www.mypalic.com
  - You may also call Customer Service at (844) 624-8110 to have the appropriate form faxed or mailed to you.
- Please **Submit** all Claim Forms, along with any other pertinent Claim Materials, via Regular Mail, to the following Address

Pan American Life Insurance Company Accident and Critical Illness
P.O. Box 981712
El Paso, Texas 79998-1712

PAN AMERICAN LIFE INSURANCE GROUP

Return to:
Pan-American Life Insurance Company
Accident and Critical Illness
P.O. Box 981712
El Paso, Texas 79998-1712
Phone (844) 624-8110

Universal Accident Claim Form

CLAIM FILING PROCEDURE

Proof of Loss (Completed claim form and a UB04 or HCFA1500) must be submitted within 90 days of the accident, additional bills must be submitted within 90 days of the date of treatment. Itemized bills must include:

- Claimant Name
- Group Number & Insured ID
- Patient Name & D.O.B
- Date of Service
- Procedure Code (CPT or Revenue Code)
- Billed Amount
- Diagnosis code (ICD format)
- Health care provider name & address
- Health care provider Tax ID number

If applicable, please attach a copy of the "Explanation of Benefits" statement from your other Insurance Carrier showing their process of the submitted expenses. Incomplete claim forms will result in a processing delay. Provider is to complete and sign the sections applicable to the injury being reported.

Claim Type:

☐ Disability ☐ Accident ☐ Death
☐ Accidental Death & Dismemberment ☐ Short Term Disability ☐ BTAC - Business Travel Accident
☐ Voluntary Accident Claim ☐ ICS - Intercollegiate Sports ☐ Trucking Occ/Acc

Section I - Policyholder Information

Policyholder Group Name			Group Number	
Top Tier Lessons			98457	
Address	City		State	Zip Code
1580 Little Texas Rd.	Travelers Rest		SC	29690
Insured's Name	Date of Birth	SSN		Phone Number
Report Date/ Date of Injury	Work Related? ☐ Yes ☐ No		Has this been filed with Worker's Compensation? ☐ Yes ☐ No	
Location where accident occurred	City		State	Zip Code
Nature of Injury				
Description of Incident				

Title _____ Signature _____ Date _____

Section II - Claimant's Information

Claimant's Name	Date of Birth	Relationship ☐ Self ☐ Spouse ☐ Child		
Date of Incident	Location of Incident. Address:	City	State	Zip Code
Description of Incident				
Does the accident or illness result from the patient's occupation? ☐ Yes ☐ No		If Yes, has this been filed with Worker's Compensation? ☐ Yes ☐ No		

Is the patient covered by any other plans for expenses related to this accident? (including, but not limited to, Medical or Automobile Insurance)
Yes ☐ No ☐ If yes, please provide the following from the Insurance Carrier:

Name _____

Address _____
(Street) (City) (State) (Zip Code)

Phone Number _____ Group Number _____ Member ID _____

Insurance Type _____ Effective Date _____ Termination Date (if applicable) _____

Signature (claimant or authorized person)	Date

Section III - Attending Physician Statement: To Be Completed by a Physician Only		
Name of patient (First, Middle, Last)	Age	Date of Accident / Date of Injury
First Consult Date		Last Treatment Date
Describe all Injuries with Diagnosis Codes		
Are any claimed conditions pre-existing or degenerative? ☐ Yes ☐ No if so, explain		
Current Treatment Plan		
Restrictions / Limitations		
Causation ☐ Accident ☐ Illness		Work Related? ☐ Yes ☐ No

Section IV - Beneficiary Information	
Is There an Assignment of Benefits or Power of Attorney? ☐ Yes ☐ No	Beneficiary Name
Address	Phone Number

Additional Comments

_____ _____

Signature of Attending Physician **Date Signed**

_____ _____

Print Name of Attending Physician **Name of Facility**

_____ _____

Address **Phone Number**

HIPAA AUTHORZATION

I HEREBY AUTHORIZE ANY DENTIST, PHYSICIAN, INSURANCE COMPANY, ORGANIZATION OR PLAN SPONSOR TO RELEASE ANY INFORMATION INCLUDING FULL COPIES OF THEIR RECORDS TO THE PAN-AMERICAN LIFE INSURANCE COMPANY, ITS ADMINISTRATION FOR ANY MEDICAL TREATMENT, SERVICES OR BENEFITS RENDERED OR PAYABLE TO ME ON MY BEHALF. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL. **I HEREBY CERTIFY THAT THE FOREGOING ANSWERS ARE TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE. WHOEVER IN ANY DOCUMENT REQUIRED BY THE TITLE OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 MAKES ANY FALSE STATEMENT OR REPRESENTATION OF FACT SHALL BE FINED NOT MORE THAN $10,000, OR IMPRISONED NOT MORE THAN FIVE YEARS OR BOTH.**

Signature (claimant or authorized person) Date

Print Name

FRAUD WARNING

For your protection, the laws of several states, including Alaska, Connecticut, District of Columbia, Delaware, Georgia, Indiana, Illinois, Idaho, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, North Carolina, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Wyoming, Wisconsin, and others require the following or substantially similar warning statement to appear on this form.

FRAUD WARNING

"Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, submits an application and/or files a statement of claim containing any false, incomplete, misleading information is guilty of insurance fraud which is a felony."

FRAUD WARNING FOR ALABAMA AND ARKANSAS RESIDENTS

"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."

FRAUD WARNING FOR ALASKA, MINNESOTA RESIDENTS

"A person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information is guilty of a crime and may be prosecuted under state law"

FRAUD WARNING FOR ARIZONA, NEW JERSEY RESIDENTS

"Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

FRAUD WARNING FOR TEXAS & CALIFORNIA and TEXAS RESIDENTS

For your protection California Law requires the following to appear in this form (for California only): **"**Any person who knowingly presents a 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."

FRAUD WARNING FOR 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."

FRAUD WARNING FOR DISTRICT OF COLUMBIA, TENNESSE, VIRGINIA AND WASHINGTON RESIDENTS

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."

FRAUD WARNING FOR FLORIDA, DELAWARE, IDAHO, INDIANA, OKLAHOMA RESIDENTS

"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."

FRAUD WARNING FOR KENTUCKY, MASSACHUSETTS, NEBRASKA AND PENSYLVANIA RESIDENTS

"Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties."

FRAUD WARNING FOR LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND, AND WEST VIRGINIA RESIDENTS

"Any person who knowingly or willfully 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 civil fines and confinement in prison."

FRAUD WARNING FOR OHIO RESIDENTS

"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 is guilty of insurance fraud."

FRAUD WARNING FOR 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."