GROUP VOLUNTARY ACCIDENT POLICY AND OPTIONAL RIDER CLAIM FORM

If you have any questions regarding benefits available, or how to file your claim, or if you would like to appeal any determination, please contact our Customer Service Center at 1-800-845-7519, 8:30 A.M. to 5:00 PM Eastern Standard Time or email us at: Claims@bbadmin.com

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

Mail, fax or email your claim to: **Bay Bridge Administrators, LLC**
P.O. Box 161690
Austin, TX 78716
Fax: 512-275-9350 **Email: Claims@bbadmin.com**
This form can be found on our website at: www.wellfleetinsurance.com or www.bbadmin.com

CERTIFICATE HOLDER / CLAIMANT INFORMATION:

CERTIFICATE NUMBER(S):_____

CERTIFICATE HOLDER: First Name:_____ MI:_____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ ☐ Male ☐ Female

Mailing Address: _____ Apt#:_____

City: _____ State: _____ Zip:_____ ☐ **Check here if address is new**

Phone #: _____ E-mail: _____

Employer: _____ Occupation: _____

CLAIMANT: (if different) First Name: _____ MI: ___ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

ACCIDENT CLAIM DETAILS: Please provide the following Accident Claim details

Please provide the date and time of the accidental injury. Accident Date: _____ Time: _____ ☐ AM ☐ PM

Is the injury work related? ☐ Yes ☐ No

Has a Worker's Compensation claim been filed? ☐ Yes ☐ No If yes, is the claim ☐ Approved ☐ Pending ☐ Denied

Was the claimant involved in a motor vehicle accident? ☐ Yes ☐ No If yes, ☐ Driver ☐ Passenger

Was a police report filed? ☐ Yes ☐ No If yes, please provide a copy of this report.

What is your Diagnosis / Condition? _____

Have you ever had the same or similar diagnosis / condition? ☐ Yes ☐ No If Yes, when: _____

Tell us exactly how your accidental injury happened: _____

_____

Where did your accidental injury happen? _____

When was your first physician visit for this accidental injury? _____

Were you hospitalized due to this accidental injury: ☐ Yes ☐ No Admission date: _____ Discharge date: _____

INSTRUCTIONS FOR REQUESTING AVAILABLE BENEFITS:

- The following are benefits available under the Accident Certificate and the Optional Riders (if purchased).
- Please select the Benefits you believe may be due based upon the Covered Person's Accidental Injury and attach the required documentation.
- The required documentation needs to include the **patient's name, diagnosis and dates of service**.
- If you are asked to provide a bill as required documentation, please ask your provider for: **UB04, HCFA1500, or an itemized bill.**
- We also require you to sign and submit the Authorization to Release Information form
- You will be notified if additional information is needed.

Benefits may vary by product and/or state. In addition, you may not have purchased the Optional Rider(s) available. Please refer to your certificate and rider(s) for specific benefits available to you.

☐ NEW CLAIM or ☐ CONTINUED CLAIM

BASE BENEFITS; NON-OPTIONAL BENEFITS (check those that apply)

Hospital Care

☐ **Hospital Admission:** Provide the inpatient hospital bill or medical records showing inpatient hospitalization with room & board charges.

☐ **Hospital Confinement:** Provide the inpatient hospital bill or medical records showing inpatient hospitalization with room & board charges

☐ **ICU Admission:** Provide the inpatient hospital bill showing charges for intensive care.

☐ **ICU Confinement:** Provide the inpatient hospital bill showing charges for intensive care.

Ambulance

☐ **Ambulance:** Provide ambulance bill or documentation of ambulance transfer ☐ **Air** ☐ **Ground** ☐ **Water**

Benefit Enhancement

☐ **Lacerations:** Provide bill showing if stitches were involved and if so the length of the laceration.

☐ **Burns:** Provide bill outlining the type of burn and if skin grafts were done.

☐ **Dislocations:** Provide bill and radiology report or medical record showing dislocation.

☐ **Fractures:** Provide bill and radiology report or medical record showing a fracture.

☐ **Concussion:** Provide bill or medical record showing concussion.

☐ **Dental Benefit:** Provide bill or medical record showing injury to a sound tooth. Records should include x-rays.
☐ **Eye Injury:** Provide bill showing surgery or the removal of a foreign body to the eye.

Catastrophic Benefits

☐ **Coma:** Provide medical records documenting a coma for 14 days or more.
☐ **Loss of:** Provide medical documentation supporting the loss. ☐ Hearing (both ears) & Speech, **OR** ☐ Hearing (both ears) or Speech, **OR** ☐ Hearing (one ear)
☐ **Dismemberment:** Provide operative report or medical record showing dismemberment as outlined in certificate. ☐ **Multiple** ☐ **Single** ☐ **Partial**
☐ **Paralysis:** Provide medical records documenting paralysis. ☐ **Paraplegia** ☐ **Quadriplegia**
☐ **Accidental Death:** Certified Death Certificate, AD&D Claim Form needs to be provided as well as other documentation listed on the Claim Form
☐ **Common Carrier Accidental Death:** see Accidental Death

OPTIONAL BENEFITS (check those that apply)

Initial Diagnosis & Treatment

☐ **Emergency Room Treatment:** Provide bill or medical record for Emergency Room Services.
☐ **Emergency Room Observation:** Provide bill or medical record for Emergency Room Observation.
☐ **Urgent Care Facility:** Provide bill or medical record for Urgent Care Facility charges.
☐ **X-Ray Benefit:** Provide bill or radiology record for X-ray which was due to an accident.
☐ **Major Diagnostic Imaging:** Provide bill or record for image which was due to an accident. ☐ **MRI** ☐ **MR** ☐ **EEG** ☐ **CT** ☐ **CAT**

Follow-up Care Benefits Related to Accident

☐ **Physician Office Visit:** Provide bill or medical record supporting accident related visit(s).
☐ **Home Health Care:** Provide bill or medical record supporting accident related visit(s). Stay must be preceded by hospital stay.
☐ **Private Duty Nursing:** Provide bill or medical record supporting accident related visit.
☐ **Residence / Vehicle Modification:** Provide bill for services and physician's certification. Accident must be: ☐ **Loss of sight** ☐ **Use of one hand or arm** ☐ **Use of one foot or leg**
☐ **Skilled Nursing Facility:** Provide bill or medical records to support stay. Confinement must be in lieu of inpatient hospital stay, preceded by inpatient hospital stay and requires a physician to visit at least once every 30 days.
☐ **Therapy Services:** Provide the bill or medical records for Physical, Occupational or Speech Therapy. All services must be prescribed by a physician.
☐ **Rehabilitation Unit Confinement:** Provide bill for the inpatient rehabilitation. Must be preceded by an inpatient hospital stay.

Accidental Surgical Benefits

☐ **Outpatient Surgery:** Provide bill or medical records supporting surgical treatment that was due to an accidental injury. ☐ **Surgery and Anesthesia** ☐ **Physician's Office or Emergency Room** ☐ **Facility other than Physician's Office or Emergency Room**
☐ **Internal Injuries:** Provide bill or medical records supporting surgical treatment that was due to an accidental injury. ☐ **Open Abdominal & Thoracic Surgery** ☐ **Exploratory Only** ☐ **Hernia Repair** ☐ **Ruptured Disc**
☐ **Tendons / Ligaments:** Provide operative report or bill showing tendon or ligament repair.
☐ **Torn Knee Cartilage:** Provide operative report or bill showing knee surgery.

Accidental Support Benefits

☐ **Crutches or Appliances:** Provide bill and physician's order.
☐ **Prosthesis:** Provide a bill for the covered prosthesis as defined in certificate.
☐ **Pain Management:** Provide a bill or medical record for ☐ **Epidural Injection** ☐ **Cortisone Injection**
☐ **Prescription Drug:** Provide copy of bill that was filled by a licensed pharmacist and ordered by a physician.
☐ **Lodging:** Provide bills for lodging for family member for when injured membered is inpatient due to an accident.
☐ **Transportation:** Provide documentation of non-local transportation. Must travel more than 100 miles.

OPTIONAL RIDERS (check those that apply)

☐	**Wellness Benefit Rider:** Provide bill for Wellness Initiative and Screenings. See Certificate for list of covered tests.
☐	**Organized Athletic Activity Rider:** Additional benefit when accident is obtained when competing in an organized athletic activity.
☐	**Emergency Sickness Rider:** Provide bill for sickness when traveling more than 100 miles from residence. See Rider for details.
☐	**Caregiver Rider:** Lump sum benefit for caregiver to a critically injured person. Provide physician's orders recommending a caregiver and that the caregiver is not able to perform their usual duties of employment due to providing caregiver functions.

CERTIFICATION: Please read and sign below

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete and correctly recorded. **Please also remember to sign and date the attached authorization required to process your claim.**

Signature: _____ Print Name:_____ Date: _____

EMPLOYER'S STATEMENT

To be completed and signed by your Employer

If you are unemployed, please provide the last day you worked. Your prior employer's name and sign this form.

SECTION #1: Employment Information / Job Description **Check here if ☐ Self-employed or ☐Unemployed**

Name of Employer/Company: _____

Date of Hire: _____ Employee's Job Title: _____

Please attach copy of job description and responsibilities.

This job is classified as: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Prior to inability to work, he/she worked _____ hours per week. Hourly Pay: $_____ Annual Salary: $_____

SECTION #2: Dates Missed Work / Return to Work

What dates was the employee unable to perform any part of their work: From_____ through _____

Has the employee returned to work? ☐ Yes ☐ No Part-time/Partial duties date: _____ Full-time date: _____

Did the employee work part-time/partial duty? ☐ Yes ☐ No Dates: _____

Is part-time/partial duty work available? ☐ Yes ☐ No Reason: _____

SECTION #3: Workers' Compensation / Other Disability Coverage

Is this a work-related condition/injury? ☐ Yes ☐ No Workers' Compensation begin date: _____ End date: _____

Workers' Compensation Carrier: _____ Benefit amount: $_____ Monthly / Weekly

Is employee covered under any other Disability Policy? ☐ Yes ☐ No

Other Disability Insurance Carrier: _____ Benefit amount: $_____ Monthly / Weekly

SECTION #4: Premium

Pre-Tax Premium: Were the premiums for this disability income paid with Pre-Tax Dollars? ☐ Yes ☐ No

If yes, FICA withholding will be deducted from the disability claim payment

Employer Paid: Were premiums for this disability income Employer paid? ☐ Yes ☐ No

SECTION #5: Employer Verification

Signed by: _____ Print Name: _____ Date: _____

Title: _____ Company: _____

Address: _____ Phone #: _____

Email address: _____

ATTENDING PHYSICIAN'S STATEMENT

To be completed and signed by the Attending Physician

SECTION #1: Describe the Condition

ICD 9/10 Code: _____ Primary Diagnosis: _____

ICD 9/10 Code: _____ Secondary Diagnosis: _____

Other Condition(s): _____

When did **Symptoms** first appear? _____ If applicable, what is the **Accident Date**? _____

Has the patient ever had the same / similar condition? ☐ Yes ☐ No When: _____

Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Pregnancy or Complication of Pregnancy: Due Date: _____ Delivery Date: _____

☐Normal Delivery ☐ C-Section

SECTION #2: Treatment Required

First Consultation: _____ Most recent consultation: _____ Next consultation: _____ Released: _____

Is a Surgical or Medical Procedure required? ☐ Yes ☐ No Date: _____ Procedure Code: _____

Procedure: _____

Is Hospitalization required? ☐ Yes ☐ No Admission date: _____ Discharge date: _____

Hospital: _____ City: _____ State: _____

What is the current treatment plan? _____

SECTION #3: Restrictions, Limitations and Ability to Work:

The patient **IS ABLE** to work in the following capacity: ☐ No Work ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

The patient **IS UNABLE** to perform their job duties: ☐ Yes ☐ No If yes: From _____ Through _____

When is the patient expected to **RESUME WORK**? Part-time Duties: _____ Full-time Duties: _____

Please provide specific **RESTRICTIONS** (what patient shouldn't do)? _____

Please provide specific **LIMITATIONS** (what patient can't do)? _____

What clinical or diagnostic findings support the above? _____

SECTION #4 Referring Physician:

Name: _____ Specialty: _____

Address: _____ Phone #: _____

SECTION #5 Attending Physician Verification:

Signed: _____ Date: _____ Phone#: _____

Street Address: _____

City/Town: _____ State: _____ Zip Code: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ Please check this box if you or your authorized representative would like to receive a copy of this form.

Claimant Information: (name of Claimant whose information will be released)

Name: _____ (Last, First, Middle)	Date of Birth: _____/___/_____
Other Name Used: _____	Social Security Number: _____-_____-_____

I authorize any licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all of the following information to Wellfleet or to persons or other organizations providing claims management services:

Description of the information to be disclosed: I understand that this Authorization for Release of Information specifically includes my permission to disclose my entire record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records (excluding psychotherapy notes); claims history including but not limited to Prescription Drug Databases, pharmacy benefits management companies, ambulance, insurance companies, medical transcripts, or the MIB; and, alcohol or drug abuse including any data protected by Federal Regulation 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations at the federal, state or local level. I also understand that work and financial information are necessary to process my claim and I give my permission to disclose related records about me including but not limited to employment, compensation, compensation sources, insurance companies, financial institutions, and government entities. By signing below, I consent to the disclosure of such information but only in accordance with the laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

Expiration: Unless revoked as discussed below, This Authorization will be considered valid for a period of twenty-four (24) months from the date this form is signed, or for the duration of the claim for benefits, whichever the shorter.

Right to Revoke: I have the right to revoke this authorization, in writing, at any time by contacting Wellfleet at the address provided on the previous page. I understand that revocation is not effective to the extent that Wellfleet has taken action in reliance on this authorization.

Claimant Rights:

1. I understand that the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

Claimant Authorization:

Signature: _____ Print Name: _____ Date: _____

Authorized Representative Information: Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless parent signing for patient under 18.

Name: _____ (Last, First, Middle)	Mailing Address: _____ _____
Relationship to Claimant: _____	Phone: _____-_____-_____

FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.

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.

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

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.

Arkansas, Louisiana, Rhode Island and West Virginia. 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.

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

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.

Delaware and Oklahoma. 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.

District of Columbia. 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 application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana. Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete or misleading information is guilty of a felony.

Kentucky. Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland. Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota. A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire. Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

Ohio. 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.

Oregon. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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.

Puerto Rico. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee, Virginia and Washington. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas. 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.

Indemnity Policy Benefit Payment
Direct Deposit Authorization Agreement

First Name | MI | Last Name | SSN

Street Address | City | State | ZIP Code

Phone | Email

Bank Name | Account No. | Routing/Transit No. | Account type: Checking Savings

Bank Address: Street, City, State, Zip | Name(s) on Bank Account

Please Attach Voided Check Here

I (we) hereby authorize Bay Bridge Administrators, LLC hereinafter call "Company" to initiate credit entries to my (our) account indicated above at the depository financial institution named above, hereinafter called "Bank," and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

Authorized Signature | Date

(Signature must match signature card on account)

Bay Bridge Administrators, LLC.
P.O. Box 161690, Austin, TX 78716
Phone: (800) 845-7519 Fax: (512) 275-9352
Email: underwriting@bbadmin.com
Website: www.bbadmin.com

BAY BRIDGE ADMINISTRATORS