

# VB Accident Claim Form

Filing	a claim for th	e: Policy	Holder 🗌 Depende	ent	
Policy	Holder's Nan	ne		Policy No	_
Date o	of Birth	Addre	SS		_
City		State	ZIP Code	Phone No. ()	_
Claim	nant Name		I	Pate of Birth	-
Date o	of Accident	Tiı	me of Accident		
First I	Date of Treatm	ent for Injur	У		
Did th	e accident occ	ur at work?	🗌 No 🗌 Yes		
Have y	ou or do you in	tend to file a V	Norker's Compensation	n or Occupational Disease Law Claim? $\Box$ No $\Box$ Y	Zes
1. 2.	What was th Describe in o	e injury caus letail how th	ed by the accident?_ e accident occurred:		
3. 4.	<b>If yes</b> Was the pati	, <b>submit a co</b> j ent tested fo	accident? No No report	gs? 🗌 No 🗌 Yes	
5. 6.	Was the pati If yes Was death th	ent treated b , <b>submit the</b> i ne result of th	blood alcohol report o by a physician or in a itemized hospital bill his injury? certified death certific	hospital? No Yes (UB04) or itemized physician bill (HCFA1500) Yes	
submits	rson, who with th s an Application of	e intent to defr or files a claim o	aud or knowing that he/s containing a false or dece	he is facilitating a fraud against an insurer, ptive statement may be subject to rific Fraud Warning Statements on page 4)	

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

Signature of Policy Holder

Date

# **VB** Accident Claim Form

### Please review the information below to ensure complete and accurate documents are submitted along with the claim form. Review Policy Certificate for specific benefiteligibility.

- 1. If the patient was transported via **ambulance** (air or ground), submit the itemized ambulance bill.
- 2. If **Coma** or **Paralysis** were the result of the injury(ies), provide medical records and/or physician office notes.
- If any of the following surgeries were performed as a result of the injury, submit a copy of the operative report: 3.
  - **Ligament Repair**
- Eye Surgery **Open Reduction (Fractures or Dislocations)**
- **Knee Cartilage Repair Tendon Repair**

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- **Rotator Cuff Repair**
- **Exploratory Surgery**
- **Ruptured Disc Surgery**
- 4. If an **extraction** or **crown** was done to repair injured tooth/teeth as a result of the injury, provide an itemized statement from the dentist and/or oral surgeon that includes diagnosis and procedure codes.
- 5. If any of the following services were rendered as a result of the injury, submit an itemized statement from the treating physician (HCFA1500) or facility(UB04):
  - **Urgent Care Visit**
  - **Doctor's Office Visit**
  - **Chiropractic Care Visit** •
  - Physical TherapyVisit ٠
  - Medical Appliance (to assist with mobility)
  - **Concussion Treatment**

- **Laceration Repair**
- **Burn Treatment**
- Fracture and/or Dislocation •
- Prosthesis
- **Received Blood or Plasma**
- 6. If any of the following services were rendered as a result of the injury, submit the itemized Hospital statement (UB04):
  - **Inpatient Hospital Admission** ٠
  - **Rehabilitation Unit Admission**
  - **Intensive Care Admission**
  - **Emergency Room Care**
- 7. If a major diagnostic exam (i.e. CT Scan, MRI, EEG) performed as a result of injury(ies), submit a copy of the exam report and itemized statement that includes diagnosis and procedure codes.
- 8. Did you suffer a **catastrophic injury** as a result of the accident? No Yes (See policy certificate for specific details)

If yes, submit medical records from the treating physician and/or hospital

9. If filing for a dependent child, did the injury occur as a result of a **youth sporting event** or **organized practice**? (See policy certificate for eligibility) No Yes

If yes, submit proof of registration in the sport league or have the Coach or League Official sign and date below.

#### **Coach or League Official Signature**

Date

#### **Coach or League Official phone number**

- 10. If you are filing for any of the below travel expenses, include receipts with the claim form. (See policy certificate for eligibility)
  - Food Lodging
  - **Use of Personal Vehicle**
  - Expenses for plane, train or bus transportation

Mail to: ManhattanLife VB Claims PO Box 926169 Houston TX 77292



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

Patient's Name

\_PolicyNo.

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 Assurance Company of America or ManhattanLife Insurance Company to receive, in writing, by photocopy, facsimile, 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 Attn: Claims Department PO Box 926169 Houston, TX 77292. This 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 thisAuthorization.

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.

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Signature	Printed Name	Date
I have legal authority* under the laws of the Stat , the individual to v above applies and execute this Authorization is	whom the use and/or disclosure of p	
	Relationship to Applicant	Date

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



#### **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.

**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.