SOUTHWEST SERVICE LIFE INSURANCE COMPANY

CLAIM FORM

P.O. Box 982005 Ft. Worth, Texas 76182-8005 (817) 284-4888

THIS FORM SHOULD BE COMPLETED BY THE POLICYHOLDER

Policy Number _______________

TO AVOID DELAY IN THE PROCESSING OF YOUR CLAIM, PROMPTLY RETURN THIS COMPLETED AND SIGNED FORM
THANK YOU

Section 1- PERSONAL INFORMATION

Insured's Name_______________________________ Social Security No.______________________Date of Birth__________________

Patient's Name_______________________________Social Security No.______________________Date of Birth__________________

Address____Phone No (day/Work/Cell)______________________________________

Are you or any of your family members covered by any other health plan, Medicare of other gov't plan? __________If yes, complete the following:

Covered person's name___________________________Relationship to you_____________Name of Health Ins. Co. and address_________________

____Policy No________________

Section 2- IF YOUR CONDITION WAS CAUSED BY SICKNESS, ANSWER THESE QUESTIONS:

For what sickness or disease were you treated?____

On what date were symptoms first noticed?________________________________On what date did you consult a doctor?____________________

Have you been treated for the same condition within the last 5 years?__________If yes, indicate date treatment began________________and the

Date you were last treated________________________Were you referred by another physician or health care provider?_______________If yes,

Name, address and phone no.____

Section 3- IF YOUR TREATMENT WAS CAUSED BY INJURIES, ANSWER THESE QUESTIONS:

When did the accident occur? At ____________o'clock__________on_______________, 20____ How did the accident occur?__________________

____Where did the accident occur? __________________________________

Was accident due to employment?___________ If yes, name of employer, address and phone no.____

Injury due to Auto accident?_____________ Did any Police Officer investigate the accident?______________ If yes, please submit a copy of the

POLICE REPORT. If yes, name of agency_______________________________________City/State____

Names of witnesses to the accident with addresses and phone numbers ____

____

If anyone else was injured, give names, addresses and phone numbers ____

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Did any person, product or property hazard cause or contribute to the injury?________If yes, who or what?________________________________

Have you had any contact with any investigator or adjustor from the other person(s) firm or insurance company?______If yes, dates of contact,

name, address and phone number____

Did you give a statement?______Did you provide information regarding the accident?______Has a release been signed?_____If yes, date________

If you are represented by a lawyer give name, address and phone no.____

Section 3 **(continued)-** WAS THE INJURY SUSTAINED AT A SCHOOL OR WHILE PATIENT ENGAGED IN ANY ATHLETIC, SPORTS OR RECREATIONAL ACTIVITY? _____________ If yes, list the school or school sponsored event, address and phone no.____

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If the injury occurred at a sporting event list the names of the sponsor, address and phone no.____

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If the injury occurred at a commercial sporting or recreational facility, give the name, address and phone no.________________________________

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Section 4- IN ORDER TO PROPERLY CONSIDER THIS CLAIM, IT IS NECESSARY FOR US TO OBTAIN A COMPLETE LIST OF NAMES, ADDRESSES AND PHONE NUMBERS OF ALL DOCTORS YOU HAVE SEEN IN THE LAST FIVE YEARS.

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When filing your claim, please include any itemized bills from providers (doctor, hospital, etc.). We cannot process claims from billing statements or receipts.

I CERTIFY THAT THE INFORMATION ON THIS CLAIM FORM IS FULL, COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE. 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. TEXAS INSURANCE CODE ARTICLE 3.97-2

I acknowledge that my health benefits plan is entitled to recover from any person or firm legally responsible for my injuries up to the amount of benefits the Plan pays for treatment of my injuries and I recognize that the Plan retains a lien on my claim against such responsible firm or person. I will not release any responsible party from liability without the Plan's written consent.

Signed by Patient, or Parent of a minor Patient____Date____________________

Section 5 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANT MEDICAL RECORDS AUTHORIZATION FORM

Patient/Primary Proposed Insured____

Address:____**City**__________________**State**____________**Date of Birth** _____/_____/______

This is an authorization under the Privacy Rules of the Health Ins Portability and Accountability Act of 1996; 45 CFR §164.508. It authorizes Southwest Service Life Insurance Co. to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health insurance operations.

The person/people/entities authorized to make disclosure to Southwest Service Life Ins. Co. is/are my physicians, medical practitioners, hospitals, clinics, medical facilities, the Pharmacy Benefit Manager, or other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance.

The confidentiality of my health care information is waived by this authorization, which permits disclosures of any and all requested parts of my medical records. I understand that re-disclosure may not be protected by the federal privacy regulations. I also understand this may include drug, alcohol, mental health, HIV or AIDS information.

This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have the right to revoke this authorization at any time and Southwest Service Life Ins. Co. must cease using this authorization. However Southwest Service Life Ins. CO. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Ins. Co. PO Box 982005 Ft. Worth, Texas 76182-8005.

Notice to my health care provider(s): An electronic signature on this HIPAA Compliant Medical Records Authorization Form has the same legal authority as a hand-written signature under both state and federal law. Please accept my e-signature as if it were my original hand-written signature.

Signature of Patient/Primary Proposed Insured________________________________Date___/___/___ Date of Birth ___/___/____

Signature of Patient/Spouse if proposed to be Insured__________________________Date___/___/___ Date of Birth ___/___/____

Signature of other Patients/Dependents 18 or over ____________________________Date___/___/___ Date of Birth ___/___/____

If Applicable Print name(s) of covered children ________________________________Date of Birth___/___/___

_______________________________Date of Birth ___/___/___ ____________________________ Date of Birth ___/___/____