The American Home
Life Insurance Company

Claims Address: P.O. Box 1497, Topeka, KS 66601

Toll-free: (800) 876-0194

Claims Fax: (785) 234-9201

Claims Email: HIPclaims@amhomelife.com

CLAIM FORM – IDEALFLEX SERIES HOSPITAL INDEMNITY INSURANCE

Claim Filing Instructions:

To ensure timely claim payments, please make sure all applicable sections of this form are completed and any supporting documentation is included at ***initial*** filing. **Claims that do not include required documentation with initial filing will be rejected and must be refiled.** Claims may be mailed, faxed or emailed to the above numbers and addresses.

Reminder: Your policy may be subject to the following standard provisions. Consult your specific policy for details.

- **30 Day Waiting Period – 30 day time period before policy benefits become active**
- **6 Month Pre-Existing Condition Exclusion – 6 month time period where the policy does not cover losses which are due to a pre-existing medical condition**
- **24 Month Contestability Period – The company has the right to review medical records for any loss incurred in the first 24 months to determine coverage eligibility.**

Insured Information (Required)

First Name	MI	Last Name	Policy number

Street Address	Date of Birth

City	State	Zip	Phone Number

Email Address

Reason for Claim (Required)

Briefly describe the nature of the event, how it occurred, and dates of care:

_____

_____

_____ Date of Illness/Injury: _____

Facility Information (Required)

Please list the details of the facility providing treatment:

Facility Name

Street Address	City	State	Zip

Telephone	Admission Date	Discharge Date

PLEASE INDICATE WHAT BENEFITS YOU ARE CLAIMING

1. BASE IdealFlex Hospital Indemnity Plan Insurance Benefits

Please checkmark all benefits to be claimed
Note the required documentation required at initial claim filing for the claim to be processed
Do not submit the claim without first obtaining the required documentation

I. Hospital Confinement
Dates – From: _____ To: _____ ☐
7 Hour Minimum Stay Required
*UB-04 OR Itemized Statement with Mandatory Info**

Other Base Benefits

I. Observation Unit
Dates – From: _____ To: _____ ☐
7 Hour Minimum Stay Required
*UB-04 OR Itemized Statement with Mandatory Info**

II. Emergency Room/Urgent Care
Dates – From: _____ To: _____ ☐
*UB-04 OR CMS-1500 OR Itemized Statement with Mandatory Info**

III. Mental Health Confinement
Dates – From: _____ To: _____ ☐
*UB-04 OR Itemized Statement with Mandatory Info**

IV. Pet Boarding (must match benefit dates)
Dates – From: _____ To: _____ ☐
Licensed Animal Facility Invoice Required
Pet Boarding Dates Must Match Hospitalization Dates

V. Travel Companion Lodging (must match benefit dates)
Dates – From: _____ To: _____ ☐
Hotel Must Be Minimum 100 Miles From Insured Current Address
Licensed Hotel Invoice Required

2. RIDER IdealFlex Hospital Indemnity Plan Insurance Benefits – Eligible Only If Purchased At Enrollment

Please checkmark all benefits to be claimed
Note the required documentation required at initial claim filing for the claim to be processed
Do not submit the claim without first obtaining the required documentation

I. Ambulance Benefit
Transportation Date: _____ ☐
*UB-04 OR CMS-1500 OR Itemized Statement with Mandatory Info**

II. Cancer Diagnosis Benefit
Diagnosis Date: _____
Type of Cancer: _____ ☐
Pathology Report

2. Rider Benefits Continued

III. Critical Accident & Accidental Death Benefit ☐
Date of Accident: _____
Describe Accident: _____
*If Critical Accident, UB-04 OR Itemized Statement with Mandatory Info**
If Accident Death, Death Claim Required

IV. Dual Hospital Confinement Benefit ☐
Dates – From: _____ To: _____
Name of Household Resident: _____
Hospitalization Dates of Insured + Household Resident Must Overlap
*UB-04 OR Itemized Statement with Mandatory Info**

V. Heart Attack and Stroke Diagnosis Benefit ☐
Diagnosis Date: _____
Diagnosis: _____
UB-04

VI. Outpatient Rehabilitation Services Benefit ☐
Chiropractic Therapy ☐
*UB-04 OR CMS-1500 OR Itemized Statement with Mandatory Info**

VII. Daily Skilled Nursing Facility Benefit ☐
Dates – From: _____ To: _____
Name of Facility: _____
Name of Hospital prior to transfer: _____
Must Follow 3+ day Hospital Stay
*UB-04 OR Itemized Statement with Mandatory Info**

VIII. Outpatient Surgical Procedure Benefit ☐
Date of Procedure: _____
Type of Procedure: _____
*UB-04 OR Itemized Statement with Mandatory Info**

IX. Lump Sum Hospital Confinement Benefit ☐
Dates – From: _____ To: _____
*UB-04 OR Itemized Statement with Mandatory Info**

3. Supporting Documentation (Required at initial filing)

All claims must include Supporting Documentation for Proof of Claim at initial filing
Checkmark the included forms and verify they contain the following mandatory claim information

_____ UB-04/CMS-1450 (Standardized claim form from your healthcare provider/hospital)
_____ CMS-1500 (Standardized claim form from non-institutional healthcare provider)
_____ Itemized Statement containing *ICD Codes (reason for treatment), CPT codes (services received), admission + discharge or service dates, provider name + address. If itemized statement supports hospital or observation confinement, board days or number of hours/units*
_____ Pathology report (document provided by healthcare provider detailing diagnosis information)
_____ Licensed Animal Facility Invoice *with pet boarding dates*
_____ Licensed Hotel Invoice with *dates of stay, name of room occupant, hotel name + address*
_____ Other (Explain): _____

PLEASE NOTE: THIS PAGE REQUIRES TWO SIGNATURES

ACKNOWLEDGEMENT

I hereby submit claim to the Company and agree that the written statements and supporting documentation is complete and correct to the best of my knowledge. I understand all benefits may be subject to a 30-day waiting period and claims in the first six (6) months of my policy may be subject to pre-existing conditions exclusions.

Insured's Signature: _____ Date: _____

CLAIMS AUTHORIZATION

I understand my Hospital Indemnity benefits may require additional investigation by the Company to determine my eligibility for benefits. I authorize any physician, hospital, pharmacy, pharmacy benefit manager, insurer, health insurance plan or any other entity that possess any diagnosis, treatment, prescription or other medical information about me to furnish such health information to The American Home Life Insurance Company for the purpose of evaluating my eligibility for insurance or to investigate claims. This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. Health information will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. My failure to sign this authorization may result in American Home Life being unable to collect information relating to me and ultimately result in denial of my application for claims. This authorization shall be valid for the period of time allowed by law of the state where this policy is delivered and may be revoked by sending written notice to The American Home Life Insurance Company. I may revoke this authorization at any time by notifying The American Home Life Insurance Company in writing to the Claims Department, The American Home Life Insurance Company, P.O. Box 1497, Topeka, KS 66601. I permit the Company or its representatives to give information about me, except HIV results, to the Company agent(s) listed in my application for insurance, its subsidiaries, any reinsurer, and any other insurer(s) from which benefits have been claimed or insurance purchased.

Insured's Signature: _____ Date: _____

STATE FRAUD NOTICES

AL - 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.

AR - 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.

AZ - 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.

CO - 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.

FL - 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.

IN - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KY - 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.

LA - 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.

MD - 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.

NM - 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.

OH - 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.

OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA - 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.

TX - 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.

WV - 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.

All Other States - 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.