Administrative Address
PO Box 17628, Winston-Salem, NC 27116
Toll-Free (833) 658-2844
Claims Fax (336) 464-2961
Claims Email: supphealthclaims@lbig.com

Liberty Bankers®
Insurance Group | *Liberty Bankers Life*

HOSPITAL INDEMNITY INSURANCE AND RIDER CLAIM FORM

PART ONE

Section A. General Instructions

- To prevent delays, please ensure all applicable sections of the form are completed and provide supporting documentation from your healthcare provider.
- Please review your policy for specific benefits covered under your plan.
- Claim forms and supporting documentation can be submitted via fax **(336) 464-2961** or email **supphealthclaims@lbig.com.** Emailing documents can facilitate in quicker claim processing.

Section B. Insured Information

FIRST	MI	LAST	POLICY NUMBER
STREET ADDRESS			DATE OF BIRTH
CITY	STATE	ZIP	PHONE NUMBER ( )
EMAIL ADDRESS			

Section C. Covered Person or Dependent Incurring Loss

FIRST	MI	LAST	DATE OF BIRTH
RELATIONSHIP TO POLICYHOLDER			

Section D. Claimant Statement

DESCRIBE THE NATURE OF THE LOSS AND HOW IT OCCURRED:

DATE OF LOSS

1. **Was the Covered Person or Dependent treated in an emergency room or urgent care facility as a result of this injury?** ☐ Yes ☐ No
   If yes, please submit the emergency room or urgent care facility discharge paperwork.
2. **Was the Covered Person or Dependent transported by an ambulance as a result of this injury?** ☐ Yes ☐ No
   If yes, please submit proof of the ground or air ambulance transport.

3. Hospital Indemnity Plan Insurance Benefits

Please indicate by checking "Yes" below whether the Covered Person or Dependent suffered any of the following losses due to injury or sickness. **Please provide a copy of the itemized statement or, HCFA 1500, UB-04 form from your provider.**

a. Hospital Confinement ☐ Yes ☐ No
If yes, please list dates. From:_____ To:_____

b. Intensive Care Unit Confinement ☐ Yes ☐ No
If yes, please list dates. From:_____ To:_____

c. Observation Unit ☐ Yes ☐ No
If yes, please list dates. From:_____ To:_____

d. Mental Health Unit ☐ Yes ☐ No
If yes, please list dates. From:_____ To:_____

e. Travel Companion ☐ Yes ☐ No
Lodging for Travel Companion during Hospital Confinement (hospital must be located more than 50 miles from policyowner's primary residence)
Number of Days (up to 10 per calender year):_____
If yes, please attach lodging receipts.

f. Pet Boarding for one or more Pets during Hospital Confinement ☐ Yes ☐ No
Number of Days (up to 10 per calender year):_____
If yes, please attach receipts for pet boarding.

4. Rider Benefits (if riders were purchased with this policy)

Please indicate by checking "Yes" below whether the Covered Person or Dependent suffered any of the following losses due to an injury or sickness. **Please provide a copy of the itemized statement, HCFA 1500, or UB-04 form from your provider.**

e. Skilled Nursing Facility ☐ Yes ☐ No
If yes, please list dates. From:_____ To:_____

f. Hospice Care Facility ☐ Yes ☐ No
If yes, please list dates. From: _____ To: _____

g. Outpatient Surgery ☐ Yes ☐ No
Date(s):_____

h. Outpatient Diagnostic Services ☐ Yes ☐ No
Including Outpatient Laboratory, Basic Services and Advanced Studies.
Date(s):_____

i. Wellness Benefit ☐ Yes ☐ No
If yes, how many visits are you claiming?_____
If yes, please list dates:_____

j. Outpatient Therapy ☐ Yes ☐ No
Date(s):_____

k. Physical, Occupational or Speech Therapy ☐ Yes ☐ No
If yes, how many visits are you claiming? _____
If yes, please list dates:_____

l. Chiropractic Therapy
If yes, how many visits are you claiming? ☐ Yes ☐ No
If yes, please list dates:_____

4. Rider Benefits Continued

m. New Prosthetic Device (following amputation) ☐ Yes ☐ No
If yes, please list date received: _____

n. Home Modification ☐ Yes ☐ No
If yes, please list date received: _____

o. Durable Medical Equipment and Appliance ☐ Yes ☐ No
If yes, please list date received: _____

PART TWO

Section A. Hospital Information (Please use attached Provider Information sheet to list contact information for additional providers you have been treated by over the past 5 years.)

Hospital Admission			
Treating Hospital:			
Address:	City:	State:	ZIP:
Telephone:	Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	

PART THREE

Section A. Acknowledgment

I hereby certify that the information I have provided in support of this claim is complete and true to the best of my knowledge. I have read the fraud notice, applicable to my state, included with this form. Liberty Bankers Life Insurance Company and I agree that this document may be electronically signed.

Insured's Signature: _____ Date: _____

Signature of Covered Person or Dependent Incurring Accident: _____ Date: _____
(Not required for minors under age 18)

STATE FRAUD NOTICES

AK - 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.

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 is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

AR, CA, and RI – 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 with 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 with the department of regulatory agencies.

DC – 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, any insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

DE – 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.

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.

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

IN – Any 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 and 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.

ME, TN, VA and WA: 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 denial of insurance benefits.

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.

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

NH - 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 NH Rev. Stat. Ann. §638:20.

NJ - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in any 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

All Other States – 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.

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PROVIDER INFORMATION SHEET

Please provide us with the contact information for all medical providers that have treated you for any condition within the past 5 years. This includes Primary Care Physicians (PCP), specialists, hospitals, and pharmacies.

Name	Address	Phone	Fax
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Liberty Bankers Life Insurance Company and I agree that this document may be electronically signed. I hereby certify that the information provided above is true and correct to the best of my knowledge. I understand that knowingly providing any false or misleading information may subject me to criminal or civil penalties.

Insured Signature _____ Date _____