State Mutual Insurance Company
PO Box 1404
Rome, GA 30162-1404
Office: 1-855-774-4495
Fax: 1-813-386-4425

Platinum® SUPPLEMENTAL INSURANCE

ACCIDENT CLAIM FORM

PLEASE NOTE: It is important that all questions be answered in full and that this form be returned to the company. Failure to complete all sections may result in a delay in processing this claim. If patient is a minor, questions should be completed by the Insured.

1. Accident Policy Number _____
2. Policyholder's Name _____
3. Patient's Name (if other than Policyholder) _____
4. Patient's Date of Birth _____/ _____/ _____
5. Address_____
   Street City State Zip
   a) If this is a permanent address change, please check here ☐
6. Phone number (_____) _____
7. Is this the initial claim for this accident? ☐ Yes ☐ No

   Please be sure to include the following information with the claim submission: medical records, physician office notes and/or billing from the facility that includes diagnosis, procedure codes and charge amounts (UB04/CMS1500 forms preferred).
8. Date of the injury: _____/ _____/ _____; Type of injury: _____
9. Describe how the injury occurred: _____

   _____
10. First Date of Treatment for this diagnosis: _____/ _____/ _____
11. Were you ever sick with this condition before? ☐ Yes ☐ No
    a) If yes, when _____/ _____/ _____
12. Was this a motor vehicle accident? ☐ Yes ☐ No (If yes, please submit a copy of the MVA report.)
13. Was death a result of this injury? ☐ Yes ☐ No (If yes, please submit the certified death certificate and autopsy report if performed.)

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14. Please provide the following information for all facilities visited due to this accident.

Facility Name:	Address:	Phone Number:	Date(s) of Service:

If any of the following were result of your injury, please provide medical records, physician office notes, and/or billing with diagnosis and procedure codes that describe the diagnosis or type of treatment received. (Please refer to your policy for definitions and a complete list of benefits).

- Physical Therapy (each date of treatment)
- Emergency Room
- Burn (including degree and size of all burned areas)
- Fracture or Dislocation (X-ray reports are needed)
- X-Ray
- Chiropractor
- Laceration (including length and method of repair)
- Dismemberment

I understand that this information will be used by State Mutual Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

_____ _____ _____

Name of Patient | Signature of Patient | Date Signed (MM/DD/YYYY)

If Patient is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign. IF PATIENT IS DECEASED, Personal Representative or Next of Kin must sign. The Furnishings of the Form is not admission of any Liability on the part of the Company.

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Authorization to Obtain Information

Instructions for completing this form:

1. Print clearly; all sections of the form should be completed to be valid.
2. This form must be signed and dated by the claimant / patient, guardian or an authorized representative below.
3. IMPORTANT: If you are filing a claim on behalf of a deceased person, please check here. ☐
4. If you are the authorized representative, please sign below and indicate your relationship to the claimant / patient / deceased. In addition, include a copy of the legal document(s) authorizing you to act on his or her behalf.
5. **Fax this form to 813-386-4425 or mail to State Mutual Insurance Co. – Platinum Claims, P.O. Box 1404, Rome, GA 30162-1404 as soon as possible to expedite claim review.**

I, or my authorized representative, hereby authorize State Mutual Insurance Company to use and/or disclose the following information about me as described below. I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.

Claimant / Insured Legal Name:	**Policy Number(s)**	**Date of Birth:**

Claimant / Insured Address:	
This authorization will be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:	**Purpose of Disclosure:** Evaluate claim(s) for benefits.
Name and address of healthcare provider and/or facility authorized to release requested information *(this section will be completed by SMIC)*:	

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment or other nonmedical facts be released to **State Mutual Insurance Company** or an entity or person acting on its behalf. This could include but is not limited to any medical professional, medical care institution, insurer (including SMIC, with respect to other SMIC coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under federal and state law such as: alcohol abuse, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
   a. State Mutual Insurance Company or another third party has taken action in reliance on this authorization; or
   b. This authorization is obtained as a condition for obtaining insurance coverage; other law may provide State Mutual Insurance Company with the right to contest a claim under the policy or the policy itself.
3. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand as a consequence of my failure to sign this authorization, State Mutual Insurance Company may not be able to process my claim for insurance benefits, resulting in a claim denial. I understand that State Mutual Insurance Company requires the information sought through this authorization to determine claim eligibility under the policy contract.

☐ **By checking this box**, I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

_____ _____

Signature of Individual Claimant or Authorized Representative | *Date (MM/DD/YYYY)*

_____ _____

Printed Legal Name of Individual Claimant or Authorized Representative | *Relationship of Authorized Representative or Authority to Act for the Individual, if applicable.*

Please retain a copy of this signed authorization for your records.

Assignment of Benefits Form

Complete this form <u>ONLY</u> if you want benefits paid to a healthcare provider/facility

I, _____hereby authorize and request that payment of benefits by State Mutual Insurance Company – Platinum Claims, be made directly to the healthcare provider and/or facility listed below:

Healthcare Provider/Facility Name: _____

Healthcare Provider/Facility Address: _____

_____

_____

_____ _____

Insured Signature **Date (MM/DD/YYYY)**

_____

Printed Legal Name of Insured

State Mutual Insurance Company

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For your protection state law requires the following statements to appear on this form.	
FRAUD WARNING STATEMENT	
Alabama	Any person who knowingly presents 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.
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.
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.
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 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
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.
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.
Tennessee	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.
Residents of All Other States	WARNING: Any person who knowingly files a claim containing false, incomplete or misleading information with intent to injure, defraud or deceive is guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
The furnishing of forms does not constitute an admission of liability on the part of the Company.	