SUPPLEMENTAL HOSPITAL CONFINEMENT INDEMNITY (GAP) CLAIM FORM

ASSURANT Employee Benefits®

FIDELITY SECURITY LIFE INSURANCE COMPANY

MAIL TO:

Assurant Employee Benefits (Home Office)
PO Box 419568 Kansas City Missouri 64141-6568
Fax 816.881.8768
aebworksiteclaims@disabilityrms.com

CHECKLIST

1. Complete STATEMENT OF INSURED below, answering all questions fully.
2. Complete separate form for each family member.
3. **ATTACH EXPLANATION OF BENEFITS (EOB) provided by the insurer for your Comprehensive Major Medical Plan, if applicable, to this claim form.**
4. **Attach copies of all medical bills. Bill must indicate date, type and place of service and diagnosis.**
5. Return this claim form, all itemized bills and EOBs to the address shown above or fax to the above number.

STATEMENT OF INSURED

Your Name	☐ Male ☐ Female	Date of Birth
Policy Number	Social Security Number	
Your Address (Number and Street)	City	State Zip Code
Name of Patient		Date of Birth

Relationship to Insured: ☐ Self ☐ Son ☐ Spouse ☐ Daughter

Describe Injury or Sickness Completely *(If injury, describe how accident occurred)*

Date of Injury or Beginning of Sickness:

Is Injury or Sickness Due to Employment? ☐ Yes ☐ No	Will You or Your Dependent File for Workers' Compensation? ☐ Yes ☐ No

NOTE TO ALL PARTIES COMPLETING THIS FORM: 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.

I certify that the information given by me in support of this claim is true and correct.

▶ _____ _____

Insured's Signature Date

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Claimant's signature _____ Date _____

Assurant Employee Benefits is the brand name for Group Hospital Confinement Indemnity insurance underwritten by Fidelity Security Life Insurance Company and administered by Union Security Insurance Company.