1.
2.
3.

1.
2.
3.

00- 1 -3 3.

00- 2-1113 0 - 23- 02

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer les a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

- ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAji CLAIM-frESTms fRcLOSSDULEUN-EFITf a loss is gui

incomplete, or misleading information is guilty of a felony.

- 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, nes, 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.

- Any person who, with a purpose to injure, defraud or deceive any insurance company, les 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.

- Any person who knowingly and with intent to defraud any insurance company or other person les a statement of claim containing any ancT criallfa

Educational Services Division
Bene ts Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160
www.american delity.com

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation Carrier. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome /AIDS Related Complex) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/

REQUEST FOR ACCIDENT
ONLY POLICY BENEFITS

2 1 0
312
1- 00- 2-1113
1- 00- 1 -3 3

A. ABOUT YOU	INSURED'S LAST NAME	First Name	Initial	Date of Birth	ACCOUNT NUMBER
	Mailing Address (City, State, Zip)				Insured's Social Security Number
	Employer - Name				Home Telephone # ( )
B. ABOUT THE PATIENT	PATIENT INFORMATION (CHECK ONE) For whom do you make this request? ☐ Self ☐ Son ☐ Wife ☐ Daughter ☐ Husband ☐ Other _____ identify				
	Patient's Name	Patient's Birth Date	Patient's Social Security No.		
C. ABOUT THE ACCIDENT	Date of Accident: _____/_____/_____				
	Type of Injury:				
	Describe how the accident occurred:				
	Are you making a claim under your Accident Only Disability bene□t? _____Yes _____No				

_____ _____

Signature Date

I veri□y this information is true and correct.

I authorize AFAC to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFAC receives written noti□cation from me of its termination in such time and in such manner as to afford AFAC and the Depository opportunity to act on it.

Signature: _____