



Aetna Accident Plan Benefits Request

Internal Use

Category Code	VPCF
Office Key Code	039

Please call our Customer Service Center at 1-800-607-3366 between 8:00 AM and 6:00 PM if you have any questions about benefits or how to file your claim, or if you wish to appeal a decision.

The completion of this form does not guarantee payment.

A. Instructions for filling out this form

1. Please check the box(es) that best describes your claim:

Covered Benefit	Check Box	Covered Benefit	Check Box	Covered Benefit	Check Box
*Accidental Death	<input type="checkbox"/>	Dislocations – Closed Reduction	<input type="checkbox"/>	Pain Management (Epidural Anesthesia)	<input type="checkbox"/>
Accidental Dismemberment	<input type="checkbox"/>	Dislocations – Open Reduction	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>
Accident Follow-up	<input type="checkbox"/>	Emergency Room	<input type="checkbox"/>	Physician's Office or Urgent Care Center	<input type="checkbox"/>
Ground Ambulance	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	Prosthetic Device/Artificial Limb	<input type="checkbox"/>
Air Ambulance	<input type="checkbox"/>	Fractures - Closed Reduction	<input type="checkbox"/>	Rehabilitation Unit - Daily	<input type="checkbox"/>
Appliances (for mobility)	<input type="checkbox"/>	Fractures - Open Reduction	<input type="checkbox"/>	Ruptured Disc	<input type="checkbox"/>
Blood/Plasma/Platelets	<input type="checkbox"/>	Hospital Stay Admission	<input type="checkbox"/>	Surgery (with repair)	<input type="checkbox"/>
Burns	<input type="checkbox"/>	Hospital Stay – Daily	<input type="checkbox"/>	Surgery (with no repair)	<input type="checkbox"/>
Burn Skin Graft	<input type="checkbox"/>	ICU – Daily	<input type="checkbox"/>	Tendon/Ligament/Rotator Cuff	<input type="checkbox"/>
Chiropractic Treatment	<input type="checkbox"/>	Laceration	<input type="checkbox"/>	Therapy Services	<input type="checkbox"/>
Coma	<input type="checkbox"/>	Lodging - provide lodging date	<input type="checkbox"/>	Torn Knee Cartilage	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	Medical Imaging	<input type="checkbox"/>	Transportation	<input type="checkbox"/>
Dental Treatment	<input type="checkbox"/>	Observation Unit	<input type="checkbox"/>	X-ray	<input type="checkbox"/>

*Please provide original death certificate and complete Sections B, C, E, F, G and J.

- Complete items in **Section B & C** in full.
- Complete **Section D** if the accident occurred on-job and provide copies of the employer incident report.
- If you had an off-job accident/injury, please provide copies of the incident and/or police report.
- Complete **Section H** if you had any transportation or lodging. Also, provide accommodation receipts and mileage to and from the treating facility.
- Complete and sign **Section K**.
- Have Physician complete **Sections I & J** in full.
- Please provide an itemized bill or UB04 form from the hospital.
- Retain copies of your bills for your record.
- Send the completed benefits request and the bills to:

Aetna Voluntary Plans **Fax to: 1-859-455-8650**
PO Box 14079 **Phone: 1-800-607-3366**
Lexington, KY 40512-4079

NOTE: INCOMPLETE CLAIM FORMS WILL DELAY THE PROCESSING OF THE CLAIM.

B. Employee and Patient Information (to be completed by Employee)

1. Employee's Name/First Middle Last		
2. Employee's address (include ZIP code) <input type="checkbox"/> Check if address is new		
3. Employee's e-mail	4. Employee's Policy/ Group Number	5. Employee's W ID # or SSN
6. Employee's Birthdate (MM/DD/YYYY) / /	7. Employee's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	8. Daytime phone number () -
9. Occupation	10. Employer Name	11. Contact number () -
12. Patient's name (if not employee)		13. Patient's W ID# or SSN (if different than above)
14. Patient's address (if different than employee)		
15. Patient's Birthdate (MM/DD/YYYY) / /	16. Patient's Gender (if not employee) <input type="checkbox"/> Male <input type="checkbox"/> Female	17. Patient's relationship to policy/certificate holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

C. Accident Details

1. Date of accident (MM/DD/YYYY) / / Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	2. Where did it happen? <input type="checkbox"/> On-Job <input type="checkbox"/> Off-Job	3. Is Accident related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Tell us exactly how your accident/injury happened.		
5. Has similar condition happened in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , state when and where.		

D. On-Job Employer Information (complete only if accident occurred On-Job)

1. Supervisor's name	2. Supervisor's phone number () -	3. Date (MM/DD/YYYY) / /
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E. Information About the Deceased

1. Deceased's Name (last, first, middle initial)		2. If deceased is known by any other name, provide Name (last, first, middle initial)			
3. Relationship to Employee	4. Social Security Number	5. Birthdate (MM/DD/YYYY)	6. Date of Death (MM/DD/YYYY)	7. Age	8. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
9. Last Residence: Street		10. City		11. State	12. ZIP

F. Information About The Beneficiary(ies)

1.		2.		3.	
1. Name					
2. Street					
3. City					
4. State (use 2 digit code)					
5. Zip					
6. Social Security Number					
7. Relationship to Employee					
8. Birthdate (MM/DD/YYYY)					
9. Main Contact Number					
10. Has benefit/ownership been assigned? <input type="checkbox"/> No <input type="checkbox"/> Yes	11. If Yes, to whom? (send copy of assignment)		12. Assignee's Social Security Number		

G. Benefit Distribution Instructions

1. Return the benefit payment directly to:

Beneficiary Other _____

H. Transportation and Lodging Benefit – Please complete the following information if you are filing a claim for transportation and/or lodging reimbursement. You will also need to send in any hotel/motel receipts and mileage information for the treating facility.

1. Transportation

Date (MM/DD/YYYY)	Name of treating facility	Address	Mileage One way
/ /			
/ /			
/ /			

2. Lodging

Date (MM/DD/YYYY)	Name of hotel/motel	Address	Mileage One way
/ / to / /			
/ / to / /			
/ / to / /			

I. Physician's Statement (to be completed by Physician)

1. Name and address of facility where services rendered		2. Date of service (MM/DD/YYYY) / /	
3. For services related to hospitalization, give hospitalization dates (MM/DD/YYYY) Admit Date: / / Discharge Date: / /			
4. Diagnosis code(s) or ICDP(s)			
1.	2.	3.	4.
6.	7.	8.	9.
5. Describe nature of accident, illness or injury			
6. Was an x-ray taken? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of x-ray:		7. Hospital stay type <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observation	
8. Has patient had similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, state when and describe.			
9. Any other diseases or illness affecting patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe.			
10. Nature of surgical procedure, if any (describe fully). Provide CPTs.			

J. Physician Verification

1. Print full name		2. Tax identification number	
3. Signature	4. Date (MM/DD/YYYY) / /	5. Phone number () -	
6. Street address, city, state and ZIP code			

K. Authorization to Release Information

For the purpose of evaluating and administering my claim for benefits, I hereby authorize the disclosure of information concerning health care advice, treatment or supplies (including that related to mental illness and HIV) provided to me and, if applicable, my dependents, to Aetna Life Insurance Company (Aetna) and its affiliates and authorized representatives. If applicable, I also authorize the disclosure of information concerning my employment. This authorization is valid for the term of the policy or certificate under which the claim has been submitted. I know that I may request a copy of this authorization, and I agree that a copy of this authorization is as valid as the original.

Signature	Printed name	Date (MM/DD/YYYY) / /
If the person signing is the legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative, please sign and print your name and indicate the relationship here.		
Signature	Printed name	Relationship

Misrepresentation Section

Any person who knowingly and with intent to injure, defraud or deceive 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.

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 9% on the total amount payable or the face amount if payments are to be made in installments until the total payment or the first installment is paid.

FRAUD WARNINGS BY STATE

NOTICE IN ALABAMA: 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.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: Any 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.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN ARIZONA: 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.

NOTICE IN 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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN 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.

NOTICE IN DISTRICT OF COLUMBIA: FRAUD NOTICE: 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.

NOTICE IN 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.

NOTICE IN MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN 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.

NOTICE IN OHIO: 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.

NOTICE IN OREGON: Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE IN 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.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE AND WASHINGTON: 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. **NOTICE IN TEXAS:** 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.

NOTICE IN WEST VIRGINIA AND 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.

NOTICE IN 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Patient Signature:

Date:

Non-Discrimination Notice

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 1-800-607-3366.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512
1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Availability of Language Assistance Services

TTY: 711

For language assistance in your language call 1-800-607-3366 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-800-607-3366. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-800-607-3366，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-800-607-3366 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-800-607-3366 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-800-607-3366. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-800-607-3366. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-800-607-3366 gratis. (French Creole)

Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-800-607-3366. (Italian)

日本語で援助をご希望の方は 1-800-607-3366 (フリーダイヤル) までお電話ください。(Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-800-607-3366 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان شما با شماره 1-800-607-3366 بدون هیچ هزینه ای تماس بگیرید. (Persian)

Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1800-607-3366. (Polish)

Para obter assistência no seu idioma, ligue gratuitamente para o 1-800-607-3366. (Portuguese)

Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-800-607-3366. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-800-607-3366. (Vietnamese)
