WELLFLEET
WORKPLACE

GROUP HOSPITAL INDEMNITY AND OPTIONAL RIDER CLAIM FORM

Submitting your claim

Submit your claim the way you like. Mail, email or fax your claim to:

Wellfleet Insurance Company
P.O. Box 15769
Springfield, MA 01115
Fax: 413-452-5486
Email: workplaceclaims@wellfleetinsurance.com

Helpful reminders

- Please complete all sections of this form, including the patient's name, diagnosis and dates of service.
- Note that a "UB04" (hospital bill), "HCFA1500" or an itemized bill is required with the claim submission.
- Make sure to sign and submit the "Authorization to Release Information to Wellfleet Form".
- The "Attending Physician's Statement" must be completed and signed by your attending physician.
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.
- Benefits may vary by product and/or state.
- We will notify you if additional information is needed.

Questions?

If you have any questions regarding available benefits or how to file your claim, or if you would like to appeal a determination, please contact our **Customer Care Team** at:

- workplaceclaims@wellfleetinsurance.com
- 1-855-664-5838, 8:30 a.m. - 5:00 p.m. EST

CERTIFICATE HOLDER/CLAIMANT INFORMATION

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

Certificate number(s):_____
Certificate holder: First Name: _____ MI: ____ Last Name: _____
Social Security Number: _____ Date of Birth: _____ ☐ Male ☐ Female
Mailing Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____ ☐ Check here if address is new
Phone # : _____ E-mail : _____
Preferred communication with Wellfleet: ☐ Email ☐ Mail
Employer : _____ Occupation : _____
Claimant (if different): First Name: _____Middle: _____ Last: _____
Date of Birth: _____ Age: _____ ☐ Male ☐ Female
Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

If services are related to an accident, complete all the accident details below.

Accident Date: _____ Accident Time: _____ ☐ AM ☐ PM
Is your condition work-related? ☐ Yes ☐ No
Has a Worker's Compensation claim been filed? ☐ Yes ☐ No
If yes, is the claim ☐ Approved ☐ Pending ☐ Denied
Was the claimant involved in a motor vehicle accident? ☐ Yes ☐ No If yes, ☐ Driver ☐ Passenger
Was a police report filed? ☐ Yes ☐ No If yes, please provide a copy of this report.
What is your diagnosis/condition? _____
Have you ever had the same or similar diagnosis/condition? ☐ Yes ☐ No If yes, when: _____
Tell us exactly how your accidental injury happened: _____
_____
Where did your accidental injury happen? _____
When was your first physician visit for this accidental injury? _____
Were you hospitalized due to this accidental injury: ☐ Yes ☐ No
Admission date: _____ Discharge date: _____

Note: If premiums for this policy were paid with pre-tax dollars, FICA withholding will be deducted from claim payment.

HOSPITAL INDEMNITY BENEFITS

Please check the benefits that apply and attach the respective medical record documentation of your condition.

☐ **Hospital Admission:** Provide proof of hospitalization.
☐ **Newborn Hospital Admission:** Provide proof of hospitalization.
☐ **ICU Admission:** Provide proof of ICU hospitalization.
☐ **Daily Hospital and/or ICU Confinement:** Provide proof of hospitalization.
☐ **Newborn Confinement:** Provide proof of hospitalization.
☐ **Surgery:** Provide itemized bill. ☐ Inpatient ☐ Outpatient ☐ Anesthesia
☐ **Initial Treatment:** Provide itemized bill. ☐ Emergency Room ☐ Observation Unit ☐ Urgent Care Facility
☐ **Supplemental Care Benefits:** Provide itemized bill.
  ☐ Post Confinement Medical Consultant ☐ Post Confinement Prescription Drugs ☐ Specialty RX
  ☐ Outpatient Therapy ☐ Diagnostic Imaging and Testing ☐ Durable Medical Equipment
☐ **Child Related Benefits:** Provide itemized bill. ☐ Well Baby Check-up ☐ Child Care Benefit
☐ **Specialty Care:** Provide itemized bill.
  ☐ Inpatient Rehab Facility ☐ Inpatient Mental & Nervous Disorder Facility
  ☐ Inpatient Substance Abuse Facility ☐ Skilled Nursing Facility ☐ Home Health Care
  ☐ Hospice Care

Optional riders

Check those that apply. Note that you may not have purchases the available optional rider(s). Please see your certificate and rider(s) for more information.

☐ **Health Screening Rider:** Provide bill for Wellness initiative and/or screening(s). See certificate for list of covered tests.
☐ **Critical Illness Rider:** Provide documentation supporting one of the listed critical illnesses included in the rider.
☐ **Value Guard Rider:** This is an additional benefit payable for covered benefits under this certificate, dependent on how long you have been covered under this certificate. No action required from the covered person.
☐ **Health System Rider:** This is an additional benefit payable for covered benefits under this certificate when treatment or services are provided in an employer-owned and -controlled medical facility. No action required from the covered person.

CERTIFICATION

Please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete and correctly recorded.

Please also remember to sign and date the attached authorization required to process your claim.

Signature: _____ Print Name:_____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT

To be completed and signed by the attending physician.

Patient's Name: _____ DOB: _____

1) Diagnosis: _____
2) When did symptoms first appear (M/DD/YYYY)? _____
3) When did patient first consult you for this condition (M/DD/YYYY)? _____
4) Has patient ever had same or similar condition? ☐ Yes ☐ No
   If "yes", state when and describe: _____
5) Describe any other diseases or infirmity affecting present condition._____
   _____
6) Nature of surgical procedure, if any (describe fully). _____
   _____
7) Date patient last examined by you: _____
   Frequency of visits: ☐ weekly ☐ monthly ☐ other _____
8) If patient is hospitalized, provide name and address of hospital.
   Hospital: _____ City: _____ State: _____
9) Date admitted (M/DD/YYYY): _____ Date discharged (M/DD/YYYY): _____
10) Name and contact info of referring physician, if any.
    Name: _____ Phone: (_____)_____
    Address: _____
    City: _____ State: _____ Zip: _____
11) Has the patient undergone surgery? ☐ Yes ☐ No
    If yes, what procedure was performed and on what date? _____
    _____

Physician verification

Signed: _____ Date: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ Please check this box if you or your authorized representative would like to receive a copy of this form.

Claimant Information

Complete the necessary information for the claimant whose information will be released.

Name: _____ (Last, First, Middle)

Date of Birth: _____/_____/_____

Other Name Used: _____

Social Security Number: _____-_____-_____

Signature of Claimant: _____

Date signed: _____/_____/_____

I authorize any: licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer; to release any and all of the following information to Wellfleet or to persons or other organizations providing claims management services:

Authorized Representative Information

Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless a parent is signing for patient under 18.

Name: _____ (Last, First, Middle)

Mailing Address:

_____

_____

Relationship to Claimant: _____

Phone: _____-_____-_____

Description of the information to be disclosed

I understand that this Authorization for Release of Information specifically includes my permission to disclose my entire record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records (excluding psychotherapy notes); claims history including but not limited to Prescription Drug Databases, pharmacy benefits management companies, ambulance, insurance companies, medical transcripts, or the MIB; and, alcohol or drug abuse including any data protected by Federal Regulation 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV-related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations at the federal, state or local level. I also understand that work and financial information are necessary to process my claim and I give my permission to disclose related records about me including but not limited to: employment, compensation, compensation sources, insurance companies, financial institutions, and government entities. By signing below, I consent to the disclosure of such information but only in accordance with the laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

Expiration

Unless revoked as discussed below, this Authorization will be considered valid for a period of twenty-four (24) months from the date this form is signed or for the duration of the claim for benefits, whichever the shorter.

Right to Revoke

I have the right to revoke this authorization, in writing, at any time by contacting Wellfleet at the address provided on the previous page. I understand that revocation is not effective to the extent that Wellfleet has taken action in reliance on this authorization.

Claimant Rights

1. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

FRAUD NOTICES

For residents of all states, other than those listed below. 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.

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.

Alaska: 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.

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.

California. For your protection Californi law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent information to obtain or amend insurance coverage or make 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.

Delaware Idaho, Indiana & Oklahoma: 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.

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 application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky. 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.

Maine: 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 a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

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

New Mexico: 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 civil fines and criminal penalties.

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.

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.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee, Virginia & 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.

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.