Fidelity Life Association: 877-352-3303
Administrative Office:
One Integrity Place
Cleveland, OH 44143

Acceleration for LTC

Employer's/Business Entity's Statement			
1. Name of Employee/Insured Person	2. Social Security No.	3. Date of Birth	
4. Phone No.	5. Group No.	6. Occupation	
7. Employee's/Insured Person's Street Address	8. City	9. State	10. Zip Code
11. Employer/Business Entity	12. Employer/Business Entity Phone No.	13. Duties	
14. Employer's/Business Entity's Street Address	15. City	16. State	17. Zip Code

Signed in (City/State) _____ This _____ Day of (Month/Year) _____

_____ _____ _____
Name of Company Signature Official Position

Claimant's Statement			
☐Home Health ☐Adult Day Care ☐Assisted Living ☐Other _____			
1. Policyholder	2. Policyholder's Social Security No.	3. Policy No.	
4. Patient's Name	5. Patient's Social Security No.	6. Phone No.	
7. Street Address	8. City	9. State	10. Zip Code
11. Type of Residence: ☐ Home ☐ Apartment ☐ Retirement Community ☐ Other _____			
12. Describe condition for which claim is being made _____ _____ _____ _____			
13. Name of Attending Physician	14. Phone No.		
15. Street Address	16. City	17. State	18. Zip Code
19. Name of Hospital	20. Date Admitted	21. Date Discharged	
22. Street Address	23. City	24. State	25. Zip Code

Name, address and telephone number of person assisting with claim (if any)			
26. Name	27. Relationship	28. Phone No.	
29. Street Address	30. City	31. State	32. Zip Code
Attach a copy of Legal Instrument. Check One: ☐Power of Attorney ☐Guardianship			

Patient or Personal Representatives Signature_____ Date_____

Assessment Form

To be completed by Case Manager, Social Security Worker, Registered Nurse or Physician

1. Patient Name	2. Date of Birth

3. Diagnosis and Concurrent Condition

1. 2.
3. 4.
5. 6.

4. Date symptom first appeared?	5. Date patient first consulted you for this condition?
6. Has Patient ever had same condition ☐Yes ☐No	7. Is Patient still under your care for this condition? ☐Yes ☐No
8. Was Patient Hospitalized? ☐Yes ☐No From To	9. Was Patient in a Nursing Home Facility? ☐Yes ☐No
10. Period Authorization for this condition From To	11. Medicare Coverage ☐Yes ☐No

12. The above listed patient requires care to perform the following Activities of Daily Living or Instrumental Activities of Daily Living.
I= Independent S=Stand-by Assistance at Arm's Length O=Needs Hands-On to Perform

Activities of Daily Living	I	S	O	**Instrumental Activities Daily Living**	I	S	O
a. Bathing				h. Medicine Admin			
b. Dressing				i. Personal Financial			
c. Toileting				j. Prepare/Cook Meals			
d. Continence				k. Use Telephone			
e. Mobility				l. Housework			
f. Transfers				m. Laundry			
g. Feeding/Eating							

13. Cognitive Impairment: ☐Yes ☐No (If "Yes", attached Clinical Test/Documentation)

14. I hereby certify that the above listed patient will be chronically ill for a period of 90 days or more: ☐Yes ☐No

15. Patient Requires: ☐Home Health Care ☐Adult Day Care ☐Hospice Program ☐Respite Care ☐Assisted Living Facility

16. Recommended Services: ☐Nurse ☐Therapist ☐Homemaker ☐Companion ☐Other

17. Total Number of Days Per Week:	18. Number of Hours Per Day:	19. Where is care being provided? ☐Home ☐Apartment ☐Retirement Community ☐Facility ☐Other

20. Name of Provider:	21. Tax ID/Social Security No.:	22. Phone No.:	
23. Street Address:	24. City:	25. State:	26. Zip Code:

27. Type of License: ☐Heath Care Agency Care ☐Adult Day Care ☐Hospice Program ☐Other

28. Print Name:	29. Degree:	30. Phone No.:	
31. Street Address:	32. City:	33. State:	34. Zip Code:

Signature_____ Date_____

Attach the following documents:

1) Plan of Care
2) Itemized Billing Statement
3) Explanation of Medicare Benefit Statements (if Medicare coverage on these services)

Required Fraud Warning Statements
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: 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.
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.
ARKANSAS: 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.
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.
DELAWARE: 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 the 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.
HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
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.
LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.
MAINE, TENNESSEE, WASHINGTON or WEST VIRGINIA: 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.
MARYLAND: Any person who knowingly ***or*** willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 N.H. Rev. Stat. Ann. § 638:20.
NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy 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.
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.
OKLAHOMA: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
VIRGINIA: Any person who, with the intent to defraud or knowingly that he/she is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.
ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an enrollment form for insurance may be guilty of a criminal offense under state law**.**

Signature:_____ Date:_____

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Administrative Office:
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Cleveland, OH 44143

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity medical or medically-related facility, laboratory, and insurance company, or other organization, institution or person having records or knowledge of the Insured's health.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. **Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
4. **The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGEMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies)
- I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for the purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand that I am entitled to a signed copy.
- A copy of their authorization will be considered as valid as the original
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature _____ Date _____

Patient/Insured's SSN _____ Patient/Insured's Date of Birth _____ Patient/Insured's Phone No. _____

Patient/Insured's Address _____

Personal Representative's (if any) Name/Signature _____

Personal Representative's Address _____

Description of Personal Representative's Authority or Relationship to Patient/Insured _____

Policy or Contract Number _____

Claimants should retain a copy of this signed document for their records.