ATLANTIC AMERICAN
Employee Benefits

Atlantic American Employee Benefits
PO Box 105185, Atlanta, GA 30348-5652
Toll Free Claim Number: (866) 458-7499

Losing a loved one is one of the most difficult life events we ever have to face. Fortunately, your loved one established a life insurance policy to help provide you and your family the support you need during this stressful time.

This guide provides information and instruction to help successfully complete and submit your claim.

What documents do I need to submit?

- Original Insurance Policy—If the original policy is not available you are required to submit a Lost Policy Affidavit
- Claim Form—Signed by the beneficiary(s)
- Certified Death Certificate
- Copy of obituary (if available)
- Physician and Authorization forms—Only required if death occurred within the first two (2) years of the policy issue date
- Police Report (if applicable)—Only required if the death was a result of an accident, suicide or a homicide

What documents do I need to submit if the named beneficiary is deceased?

- Copy of the death certificate of named beneficiary
- Or, copy of obituary of the named beneficiary

What documents do I need to submit if beneficiary is a minor (under age 18)?

- Copy of Social Security Card
- Copy of Birth Certificate
- A Uniform Gifts to a Minors Account (UTMA) must be established with your local bank by the custodian and a copy of the account information must be submitted.

What documents do I need to submit if the life proceeds are assigned to a funeral home?

- Assignment form provided by the funeral home

What documents do I need to submit if the claim is being paid to an estate or a trust?

- Letters of testamentary
- Letters of administration
- Other qualifying legal documents issued by the probate court
- Copy of the trust documents (if applicable)

Please mail these forms back to the following address:

Bankers Fidelity Life Insurance Company
Attn: Claims Operations Department
PO Box 105185
Atlanta, GA 30348-5652

If you need any immediate assistance, you may reach our Claims Operations Department at (866) 458-7499.

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Mail To: **Atlantic American Employee Benefits**
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LIFE CLAIM FORM

Policyholder Information		
Name of Deceased (First, Middle & Last)		
Policy #	Date of Birth	Date of Death
Manner of Death ❒ Natural ❒ Accidental ❒ Suicide ❒ Homicide		

Beneficiary/Claimant Information	
Name of Beneficiary (First, Middle & Last)	Relationship to Deceased
Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Email Address	Beneficiary Phone Number
Beneficiary Address (Address, City, State, Zip)	

Funeral Home (if applicable)	
Name of Funeral Home	
Funeral Home Address (Address, City, State, Zip)	Funeral Home Phone Number

Trustee (if applicable)	
Name of Trustee (First, Middle & Last)	
Tax ID of Trustee	Trust Agreement Date

Beneficiary or Trustee Signature	Printed Name	Date
Legal Representative of the Estate Signature (if applicable)	Printed Name	Date

NOTICE

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Alabama Residents Only
WARNING: 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.

Arkansas Residents Only
WARNING: 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.

District of Columbia Residents Only
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 Residents Only
WARNING: Any person who knowingly and with intent to injury, 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.

Louisiana Residents Only
WARNING: 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.

Maryland Residents Only
WARNING: 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 may be guilty of insurance fraud as determined by a court of competent jurisdiction.

Pennsylvania Residents Only
WARNING: 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.

Tennessee Residents Only
WARNING: 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.

Virginia Residents Only
WARNING: Any person who, with the 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 may have violated state law.

Washington Residents Only
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

ATLANTIC AMERICAN EMPLOYEE BENEFITS

4370 Peachtree Road, NE, Atlanta, Georgia 30319

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

Name of Insured (please print) _____ Date of Birth _____

Social Security Number _____ Policy Number _____

I (the undersigned), the beneficiary or personal representative acting on behalf of the insured, authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of the above named insured to Bankers Fidelity Life Insurance Company®, in their capacity as underwriter and administrator of Atlantic American Employee Benefits insurance products.

Personal Information to be released:

- data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition the insured may now have or have had;
- any information regarding insurance or benefit plan coverage, claims or benefits; and/or
- any information, data or records regarding the insureds activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

I understand that the Personal Information will be used by Bankers Fidelity Life Insurance Company to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid.

I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this Authorization at any time by providing a written request to Bankers Fidelity Life Insurance Company at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Bankers Fidelity Life Insurance Company receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

❑ I am the Beneficiary of the person whose health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

If signing as Beneficiary, documents granting you the authority to grant permission to release the insureds records must be submitted.

Printed Name of Insured's Beneficiary _____ Signature of Insured's Beneficiary _____ Date _____

❑ I am the Legal Representative of the person whose health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

If signing as Legal Representative, a copy of the executed Power of Attorney, Guardianship or other similar documents granting you the capacity to represent the insured or act on their behalf, must be submitted.

Printed Name of Insured's Personal Representative _____ Signature of Insured's Personal Representative _____ Date _____

Description of Authority of Personal Representative _____

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PO Box 105185, Atlanta, GA 30348
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Medical Information Request Form

INSURED NAME (First, Middle & Last)	**POLICY/CERTIFICATE NUMBER**

Please provide the names, complete addresses and telephone numbers of all physicians, hospitals and pharmacies who have treated or dispensed medication to the insured within the last 5 years in the area below.

1. PRIMARY CARE PHYSICIAN	Telephone Number (_____) _____
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____
2. PHARMACY NAME	Telephone Number (_____) _____
Street Address	
(City, State & Zip Code)	
3. HOSPITAL/CLINIC	Telephone Number (_____) _____
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____
4. NURSING HOME	Telephone Number (_____) _____
Street Address	Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)	Date Last Seen Mo. _____ Yr. _____

5. OTHER PROVIDER	Telephone Number (_____) _____	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

6. OTHER PROVIDER	Telephone Number (_____) _____	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
7. OTHER PROVIDER	Telephone Number (_____) _____	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
8. OTHER PROVIDER	Telephone Number (_____) _____	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
9. OTHER PROVIDER	Telephone Number (_____) _____	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
10. OTHER PROVIDER	Telephone Number (_____) _____	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

*If additional space is required please use a separate sheet of paper. The more complete the information the quicker we will be able to conclude our review.