BlueCross BlueShield of Montana

Accidental Dismemberment Claim Form

Return to Blue Cross and Blue Shield of Montana at:
Attention: Claims Department
P.O. Box 7070
Downers Grove, IL 60515

Phone Number: (866) 739-4090
Fax: (312) 540-4706

INSTRUCTIONS

Upon a Dismemberment due to an Accident to an insured employee, plan member or insured dependent, the employer/administrator must complete the claim form as indicated and send with all necessary attachments.

Please submit the following documentation:

1. Claim Form:
   Part 1 – Completed by the Employer/Administrator Part
   Part 2 – Completed by the Insured/Claimant
   Part 3 – Completed by the Attending Physician

2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.

3. If the benefits are based on salary, submit payroll records verifying the employee's annual earnings at the time of their death.

4. If any portion of coverage is paid for by the employee, submit proof of payroll deduction.

5. For accidental dismemberment benefits, provide the below items, including but not limited to:

   a. Official complete police report
   b. Newspaper clippings
   c. Doctor's report, including laboratory findings and or/toxicology report.

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Part 1 – To be completed by Employer/Administrator

Statement of Employer

Employer/Plan Information

Group Name _____ Subsidiary Name _____

Group Number _____

Address _____ (Street) _____ (City) _____ (State/Zip)

Name and Title of Authorized Representative _____

Phone Number _____ Fax Number _____

E-mail Address _____

Insured Person Information

Employee/Claimant Name _____

If Dependent, Name of Dependent _____ Relation to Employee _____

Employee Social Security No. _____ Date of Birth _____

Address: _____ (Street) _____ (City) _____ (State/Zip)

Hire Date _____ Insurance Effective Date _____ Occupation _____

Annual Salary _____ Date of Last Salary Increase _____

Amount of Insurance:		Additional Benefits:	
	Basic Life		
	Supplemental Life		
	AD&D		
	Voluntary Life		
	Dependent Life		

Last Day Worked _____ Reason for cessation of work _____

If Disabled, Provide date of disability _____

If deceased is a dependent spouse or child, complete the following:

Dependent's most recent Employer _____ Last Day Worked _____

If dependent is a child, is he/she a full-time student ☐Yes ☐No Name of School _____

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative _____

Print Name _____ Date _____

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Part 2 – To be completed by Insured or Claimant

Name _____ _____ _____
Last First Middle

Date of Birth _____ HT _____ WT _____ Social Security No. _____

Address: _____ _____ _____
Street City State/Zip

Phone _____ E-mail _____

Relationship to deceased _____

Are you a U.S. Citizen: ☐Yes ☐No (If No – IRS Form W-8 required)

Date of Accident _____ Date of Loss _____

Name of Treating Physician _____ Phone _____

(If multiple physicians, please list all. Attach separate sheet if necessary)

Location of Treating Physician

_____ _____ _____
Street City State/Zip

Name of Hospital where treatment was received _____

(If multiple hospitals, please list all. Attach separate sheet if necessary)

Location of Hospital

_____ _____ _____
Street City State/Zip

Hospital Phone Number _____

Admission Date _____ Discharge Date _____

Describe the loss for which benefits are being claimed. (Attach separate sheet if necessary)

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AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Insured Name _____ (Last) _____ (First) _____ (Middle) Date of Birth _____

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical and psychological reports; records, charts, notes – excluding psychotherapy notes -, x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to: Blue Cross and Blue Shield of Montana
  P.O. Box 7070
  Downers Grove, IL 60515
- I understand the information obtained by use of this Authorization will be used by Blue Cross and Blue Shield of Montana (BCBSMT) (The Company) to evaluate my claim for death benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As otherwise may be required by law or as I further authorize.

I further understand that refusal to sign this Authorization may result in the denial of benefits.

- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent;
  - The Company has taken action in reliance on this Authorization; or
  - The Company is using this Authorization in connection with a contestable claim.

If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the company at the above address.

- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this Authorization.

SIGNTAURE _____ Date _____

Print Name _____

Claimant/Legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Relationship to Claimant/Insured or personal/legal representative signing for Claimant/Insured _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone No. _____

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Part 3 – Attending Physician's Statement

Name of Patient _____ Gender _____ Date of Birth _____

Employee Name if other than Patient _____

Address _____ _____ _____
Street City State/Zip

Date of Accident _____ Date First Consulted _____

Was the loss sustained as a result of this accident? _____

If the loss was sustained as a result of this accident, please explain:

As a result of this accident, did the patient suffer loss of any of the following? (please check all that apply)

Hand ☐Right ☐Left Foot ☐Right ☐Left ☐Hearing* Sight* ☐OS ☐OD ☐Paralysis ☐Other

*Is loss of sight or hearing complete and irrevocable ☐Yes ☐No

Please describe the loss as indicated above and provide any additional remarks:

Specialist Referral _____

Physician Name _____ Speciality _____

Address _____ _____ _____
Street City State/Zip

Telephone _____ Fax _____ EIN/SSN _____

SIGNTAURE _____ Date _____

BlueCross BlueShield of Montana

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

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.

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

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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Maryland: Any person who knowingly or willingly 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.

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 knowingly 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: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

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 be 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.

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.

Tennessee: 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.

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.

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

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

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.

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.

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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing 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.

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 NH 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.

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.

FOR APPLICATIONS ONLY:

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.