NEXSTEP HOSPITAL CONFINEMENT INDEMNITY (GAP) CLAIM FORM

FIDELITY SECURITY LIFE INSURANCE COMPANY

MAIL TO: Special Insurance Services
6509 Windcrest Drive, Suite 200
Plano, TX 75024

CHECKLIST

1. Complete STATEMENT OF INSURED below, answering all questions fully. ☐
2. **ATTACH EXPLANATION OF BENEFITS (EOB) provided by the insurer for your Comprehensive Major Medical Plan, if applicable, to this claim form.** ☐
3. Attach copies of all itemized bills. Bills must indicate date, place of service and diagnosis. ☐
4. Return this claim form, all itemized bills and EOBs to the address shown above. ☐

STATEMENT OF INSURED

Your Name	☐ Male ☐ Female	Date of Birth
Policy Number	Social Security Number	
Your Address (Number and Street)	City	State Zip Code
Name of Patient		Date of Birth

Relationship to Insured: ☐ Self ☐ Son ☐ Spouse ☐ Daughter

Describe Injury or Sickness Completely *(If injury, describe how accident occurred)*

Date of Injury or Beginning of Sickness:

Name and Address of Physician Who First Treated This Condition	Date First Treated

Is Injury or Sickness Due to Employment? ☐ Yes ☐ No	Will You or Your Dependent File for Workers' Compensation? ☐ Yes ☐ No

Are you or your dependent covered under any other insurance plan (including Blue Cross & Blue Shield), Student Accident, Hospital Indemnity or Government plan? ☐ Yes ☐ No

If "Yes", please specify insurance carrier's name, address, policy number and daily benefit amount, if applicable, for any other insurance plan that you currently have, or any plan that has terminated since the effective date of your coverage under The Benefit Bridge.

Name of Company	Address	Coverage Type	Policy Number	Benefit Amount	Termination Date (if applicable)

NOTE TO ALL PARTIES COMPLETING THIS FORM: 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.

I certify that the information given by me in support of this claim is true and correct.

Insured's Signature _____ Date _____

IMPORTANT! PLEASE COMPLETE THE AUTHORIZATION ON REVERSE SIDE OF THIS FORM

FSL
FIDELITY SECURITY LIFE INSURANCE COMPANY

P.O. BOX 418131 • 3130 BROADWAY • KANSAS CITY, MO 64141-8131
800-648-8624 (ALL AREAS) • FAX 816-968-0560

This authorization complies with the HIPAA Privacy Rule.

_____ _____/_____/_____
Name of proposed insured/patient **(please type or print)** Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Fidelity Security Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Fidelity Security Life Insurance Company may: 1) underwrite my applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Fidelity Security Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64111-8131, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that Fidelity Security Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Fidelity Security Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that my authorized representative or I have received a copy of this authorization.

_____
Signature of Proposed Insured/Patient or Personal Representative Date

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