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SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Select Benefits
Mailing Address: Symetra Select Benefits
PO Box 440 | Ashland, WI 54806
Overnight deliveries to: 118 3rd St E | Ashland, WI 54806
Phone 1-800-497-3699 | Fax (715) 682-5919

ACCIDENT CLAIM FORM
Select Benefits

TO BE COMPLETED BY CERTIFICATEHOLDER *(See attached notice)*

Full name of Certificateholder *(Please print)* _____
Certificateholder Phone Number _____

Address *(Street, city, state, zip code)* _____
_____

Patient's name and address *(Complete only if Patient is someone other than Certificateholder)*
_____
_____
_____

Patient's relationship to Certificateholder: ☐ Spouse ☐ Child *birth date* _____ ☐ Other _____

Name of Policyholder _____ Group number _____

INFORMATION ABOUT THE ACCIDENT/INJURY

Date of accident/injury _____ Where did the accident/injury occur: ☐ Home ☐ Work ☐ Other

Describe how injury occurred: _____
_____
_____
_____

What part of your body was injured? _____

Please mark any below that apply to this accident/injury:

☐ Ambulance Transport	☐ Emergency Room Visit	☐ MRI
☐ CT Scan	☐ X-Ray	☐ Other Diagnostics
☐ Dislocation	☐ Fracture	☐ Emergency Dental Work
☐ Laceration	☐ Burn	☐ Paralysis
☐ Physical Therapy	☐ Chiropractic Services	☐ Prosthetic Device

Were you confined to the hospital as a result of this injury? ☐ No ☐ Yes
If Yes, What dates were you confined to the hospital? _____

Did your injury result in the need for Durable Medical Equipment (DME) of any kind? ☐ No ☐ Yes

Did your injury result in having a surgical procedure performed? ☐ No ☐ Yes
If Yes, Please describe _____

Are you receiving ongoing treatment as the result of your injury? ☐ No ☐ Yes
If Yes, Please explain _____
_____
_____

1. To expedite your claim please include a copy of your itemized bill for services or a claim form given to you by your Provider (doctor's office, clinic, hospital or similar).

   ****If itemized bill is not available, please complete lower portion of this document with as much information as available for each provider you were treated by. Our office will attempt to obtain this information on your behalf.****

   - ☐ Patient name
   - ☐ Provider name and address
   - ☐ Diagnosis or ICD-10 code(s) (description of the medical condition)
   - ☐ Procedure or CPT or revenue codes (indicates the services rendered)
   - ☐ Charges
   - ☐ Date(s) of service

2. An Authorization for Release of Medical Information form (Authorization) may be required for our use in the event we deem it necessary to contact the Provider to obtain proof of loss/claim due to incomplete or illegible information or other reason. If you receive an Authorization, it is because we do not have a current form on file for the Patient. Please sign and return the Authorization (if enclosed) with your proof of loss/claim.

Provider Name _____ Provider Phone Number_____
Provider Address _____ Provider Fax Number_____

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Provider Address _____ Provider Fax Number_____

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Provider Address _____ Provider Fax Number_____

Provider Name _____ Provider Phone Number_____
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Provider Address _____ Provider Fax Number_____

Provider Name _____ Provider Phone Number_____
Provider Address _____ Provider Fax Number_____

Use additional sheet if necessary

Benefits are subject to eligibility at the time of service and to any coverage limitations that may apply. Proof of loss/claim satisfactory to Symetra Life Insurance Company is required before payment of benefits. Benefits can only be determined after receipt of proof of loss/claim; this form is not a guarantee of payment.

I, the undersigned Certificateholder, do certify that the information I have given is true, correct, and complete to the best of my knowledge. Further, I certify that I have read the attached fraud notice.

Signature of Certificateholder Date

FRAUD WARNINGS

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she 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.

AL: 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.

AR, LA, RI, WV: 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.

AZ: 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.

CA: For your protection California law requires the following to appear hereon: 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.

CO: 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.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: 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.

FL: Any person who knowingly and with 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.

ME: 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.

MD: 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.

NH: 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.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: 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.

OK: WARNING: 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 any false, incomplete or misleading information is guilty of a felony.

PA: 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.

TN, VA, WA: 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.

TX: 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.