ACCIDENT SAFEGUARD — ACCIDENT INDEMNITY CLAIM FORM
Golden Rule Insurance Company
UnitedHealthcare Life Insurance Company

UnitedHealthcare®

Instructions for Filing Your Claim:

1. Fill out this form completely. Failure to do so could result in a delay in processing this claim.
   NOTE: A separate claim form must be submitted for each patient.
2. Parts 1 & 2 are required to be submitted along with all supporting documents and itemized bills.
3. If the claim is for the Accidental Death Benefit, Parts 3 & 4 must also be completed and supporting documents submitted.
   NOTE: A certified copy of the Death Certificate must be mailed. Faxed copies will not be accepted.

Mail or fax all forms and documents to: **Claims Department**
PO Box 31374
Salt Lake City, UT 84131-0374

Fax to: 1-801-478-7581

If there are any questions about what benefits are covered or how to use this form, please contact our customer service department at **1-800-657-8205**, or refer to your plan documents.

PART 1: PRIMARY INSURED & PATIENT INFORMATION

Primary Insured Name:		Policy Number:	
Address:	City:	State:	ZIP Code:
Daytime Phone Number:			
Patient Name:		Patient Date of Birth:	

PART 2: REASON FOR CLAIM — CHECK ALL APPROPRIATE BOXES.

❑ **Claim is for Accidental Death benefit.** (Parts 3 & 4 must also be filled out completely.)
Submit a certified copy of the Death Certificate, a copy of the obituary, and a copy of the police report (if applicable).

❑ **Claim is for Accidental Injury.** *Submit itemized bills and a copy of the police report (if applicable).*
❑ Accident was related to a motor vehicle accident.

Date of Accident: ____/____/____ Description of Accident Details: _____

_____

(Attach a separate sheet if necessary.)

❑ **Claim is for Dismemberment benefit.** *Submit copies of medical records.*

❑ Loss of sight of both eyes
❑ Loss of both hands and both feet
❑ Loss of both hands or both feet
❑ Loss of one hand and one foot
❑ Loss of one hand, one foot, or sight of one eye
❑ Loss of one or more fingers or toes

❑ **Claim is for Specific Injury Benefit.** *Submit copies of medical records.*

❑ **Burns**
❑ Extent of Burn (% of Body Surface)
❑ Less than 10%
❑ 10% to less than 20%
❑ 20% to less than 30%
❑ 30% to less than 40%
❑ 40% or greater
❑ Burn requiring skin graft

❑ **Coma**

❑ **Concussion**

❑ **Dental Injury**
❑ Extraction of teeth
❑ Treatment with crowns

❑ **Eye Injury**
❑ Removal of foreign object by a doctor
❑ Surgical Treatment

❑ **Claim is for Specific Injury Benefits** *(continued)*

❑ **Fracture**

- ❑ Coccyx
- ❑ Finger
- ❑ Foot (other than toes or heels)
- ❑ Hand (other than finger)
- ❑ Hip
- ❑ Leg
- ❑ Lower jaw
- ❑ Nose or heel
- ❑ Rib
- ❑ Shoulder blade or forearm
- ❑ Skull (depressed)
- ❑ Skull (not depressed)
- ❑ Toe
- ❑ Upper Jaw, upper arm, or face
- ❑ Vertebral body, pelvis, or sternum
- ❑ Vertebral process
- ❑ Wrist, elbow, ankle, or kneecap
- ❑ Chip Fractures, or those not closed by reduction

❑ **Laceration**

❑ Total length of all lacerations expressed in centimeters

- ❑ Less than 5 cm and requiring sutures
- ❑ 5-15 cm and requiring sutures
- ❑ More than 15 cm and requiring sutures
- ❑ Not requiring sutures

❑ **Paralysis**

- ❑ Paraplegia
- ❑ Quadriplegia

❑ **Reduction of Dislocation**

- ❑ Ankle/Foot (other than toes)
- ❑ Bones of the hand (other than fingers)
- ❑ Collarbone
- ❑ Elbow or wrist
- ❑ Hip
- ❑ Knee
- ❑ Lower jaw
- ❑ One toe or one finger
- ❑ Shoulder
- ❑ Dislocations reduced with non-general anesthesia or no anesthesia

❑ **Surgical Procedures**

- ❑ Arthroscopy without repair
- ❑ Open abdominal (including exploratory laparotomy, cranial, hernia, or thoracic surgery)
- ❑ Other surgeries requiring general anesthesia that are not covered elsewhere

Repair of:

- ❑ Ruptured/Herniated discs
- ❑ Tendons or ligaments
- ❑ Torn Knee cartilage
- ❑ Torn rotator cuff

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

To process a claim for benefits, I authorize any health care provider or facility, pharmacy, government agency, insurance company or benefit plan administrator having information as to the care, advice, treatment or diagnosis of the patient named below, to provide any and all of this information to Golden Rule Insurance Company or UnitedHealthcare Life Insurance Company, or any agent or independent administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request, and that I have the right to revoke any authorization by notifying Golden Rule Insurance Company or UnitedHealthcare Life Insurance Company in writing. I understand that revocation of or failure to sign an authorization may impair Golden Rule Insurance Company or UnitedHealthcare Life Insurance Company's ability to evaluate or process a claim, and may be the basis for denying claims for benefits.

A copy of this shall be as valid as the original. This authorization is valid for 12 months from the date signed.

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 is guilty of insurance fraud.

Warning: For your protection Florida law requires the following statement to appear on this form. 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.

Warning: 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.

_____

Name of Patient *(Please Print)*

X _____ _____

Signature of Patient or Authorized Representative **Date**

PART 3: ACCIDENTAL DEATH BENEFIT - DECEASED PERSON INFORMATION

Submit certified copy of Death Certificate, a copy of obituary, and a copy of the police report (if any).

Deceased Person's Name:		Date of Birth:	
Last Legal Residence:	City:	State:	ZIP Code:
Date of Death:	Cause of Death:		
Relationship to Insured:			

PART 4: ACCIDENTAL DEATH BENEFIT - BENEFICIARY INFORMATION *(Attach a separate sheet if necessary.)*

Beneficiary Name:		Date of Birth:	
Beneficiary Address:	City:	State:	ZIP Code:
Beneficiary Phone Number:	Relationship to Deceased:		
If you are not the beneficiary, in what capacity do you make this claim:			

Beneficiary Name:		Date of Birth:	
Beneficiary Address:	City:	State:	ZIP Code:
Beneficiary Phone Number:	Relationship to Deceased:		
If you are not the beneficiary, in what capacity do you make this claim:			

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge.

Warning: Any person who knowingly and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing false, incomplete, or misleading information may be guilty of a crime and may be prosecuted under state law. Penalties may include imprisonment, fines, and denial of insurance benefits.

Warning: 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.

Beneficiary or Other Claimant *(Please Print)*	**X** **Signature of Beneficiary or Other Claimant**	**Date**
Beneficiary or Other Claimant *(Please Print)*	**X** **Signature of Beneficiary or Other Claimant**	**Date**
Legal Guardian (if applicable) *(Please Print)*	**X** **Signature of Legal Guardian (if applicable)**	**Date**
Witness *(Please Print)*	**X** **Signature of Witness**	**Date**