ACCIDENT SAFEGUARD PREMIER: ACCIDENT EXPENSE 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. Part 3 must be completed in full if you have medical insurance in addition to this policy.

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.

As Required by Michigan law, reimbursement will be made directly to the provider of covered medical transportation services if that provider has not received payment for those services from any other source.

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 injury. *Submit itemized bills.* If applicable, also submit Explanation of Benefits from medical insurance and a copy of the police report.

❑ Accident was related to a motor vehicle accident. *Submit itemized bills and a copy of the police report.*
Date of Accident: ____/____/____ Description of Accident Details: _____

_____

(Attach a separate sheet if necessary.)

PART 3: MEDICAL INSURANCE INFORMATION

❑ Yes, there is medical insurance in addition to this policy. *(Please complete the section below).*
Note: You must submit Explanation of Benefits from your medical insurance in order for us to process the claim under this policy.

❑ No, there is no medical insurance in addition to this policy.

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

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 **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.

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.

For Florida residents only: ❑ Payment to be made to the provider of service.

_____

Name of Patient *(Please Print)*

X _____ _____

Signature of Patient or Authorized Representative **Date**