

**Claim Filing Procedures**  
(Accident and Sickness claims only)  
for The Major Complement

Please submit clear copies or originals of all required paperwork.

Although the claims process is simple, it **requires YOUR PARTICIPATION.** Please follow the instructions below so that we may process your claim on a timely basis.

**An ID card is included** with your certificate – please carry it with your major medical ID card. When visiting a provider, present both cards. Providers can then verify both your major medical and supplement coverages, and know where to submit claims for processing. Although every provider has their own procedures for deductible expenses, presenting the card should alert them to the fact that you have a supplemental plan designed to alleviate you having to pay this expense up front. Encourage your provider to contact our customer service department if they have questions as to how the plan works and we will be happy to assist.

For covered Physician visits, In Patient Hospital Confinements, and Out Patient Services, **SIS will need the following in order to process your claim:**

1. A completed claim form. A form is not required for every physician visit, however, we will need at least one in your file annually. Remember to include a completed claim form with your first submission for each year. Be sure to complete the Statement of Insured on the claim form, sign and date the authorization section, and sign and date the claim form for your dependent children (if covered and submitting a claim on their behalf).
2. A copy of the original itemized bill. If your provider has not submitted this directly to us, it is up to you to obtain a copy and submit it for claims processing. The itemized bill must show the diagnosis for your visit, date of service, itemized charges, and the name/address/tax ID of the provider. **A balance due statement is not sufficient.**
3. A copy of the explanation of benefits from your major medical carrier that corresponds to each itemized bill. This is the statement from the primary carrier that tells what charges they are paying, denying, or applying to deductibles, etc. If you participate in an HMO, you will most likely not receive an explanation of benefits. In this case, please be sure the itemized bill you submit includes any HMO payment amount, discounts, write offs, or copays that were paid to the provider.

You may mail, fax or e-mail these items to:

ATTN: Claims Department  
Special Insurance Services, Inc.  
PO Box 250349  
Plano, TX 75024-0349  
Fax: (972) 960-0377 or (214) 291-1301

SIS Customer Service:

(800) 767-6811 or [customerservice@specialinc.com](mailto:customerservice@specialinc.com)

**IMPORTANT!!** The Out Patient II benefit is a "per family per calendar year" benefit. The calendar year maximum payable for any one individual within the family unit, however, will not exceed 50% of the family calendar year maximum. The calendar year maximum payable for any covered person who has selected Employee Only coverage, will not exceed 50% of the family calendar year maximum shown in the Policy/Certificate.

# HOSPITAL CONFINEMENT INDEMNITY (GAP) CLAIM FORM



FIDELITY SECURITY LIFE INSURANCE COMPANY.

MAIL TO: SPECIAL INSURANCE SERVICES, INC.  
 PO BOX 250349  
 PLANO, TX 75025-0349  
 (800) 767-6811 – phone; (214) 291-1301 – fax  
 Email: customerservice@specialinc.com

## 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. Return this claim form, all itemized bills and EOBs to the address shown above.

## STATEMENT OF INSURED

Your Name		<input type="checkbox"/> Male	<input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter					
Does Patient have a Medicare Health Insurance Claim Number (HICN)?				If "Yes", please provide HICN #:	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Describe Injury or Sickness Completely ( <i>If injury, describe how accident occurred</i> )					
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?			Will You or Your Dependent File for Workers' Compensation?		
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you or your dependent covered under any other insurance plan (including Blue Cross & Blue Shield), Student Accident, Hospital Indemnity or Governmental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Hospital Confinement Indemnity plan.					
Name of Company	Address	Coverage Type	Policy Number	Benefit Amount	Termination Date
<p><b>NOTE TO ALL PARTIES COMPLETING THIS FORM:</b> 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.</p> <p style="text-align: center;">***NOTICE – See State Specific Fraud Notices on Next Page***</p> <p>I certify that the information given by me in support of this claim is true and correct.</p>					
<div style="display: flex; justify-content: space-between; align-items: center;"> <span style="font-size: 1.2em;">▶</span> </div>					Date
Insured's Signature					

**IMPORTANT! PLEASE COMPLETE THE AUTHORIZATION INCLUDED WITH THIS FORM**



c/o SPECIAL INSURANCE SERVICES, INC. • P.O. BOX 250349 • PLANO, TX 75025-0349  
800-767-6811 • FAX 214-291-1301 • EMAIL customerservice@specialinc.com

**AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION**

I authorize the disclosure of health information regarding, or related to:

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Policy No. \_\_\_\_\_  
Claim No. \_\_\_\_\_

- I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This Authorization permits the disclosure of all medical records including without limitation those containing information relating to, diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.
- I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this Authorization does not authorize the release of psychotherapy notes.
- I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.
- I authorize Fidelity Security Life Insurance Company, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this Authorization.
- The purpose of the disclosure authorized herein is to permit Fidelity Security Life Insurance Company, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to administer the above-referenced individual's health insurance coverage.
- This Authorization shall expire twenty-four (24) months after the date on which it is executed below.
- I understand that eligibility for the health plan is conditioned on my execution of this Authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.
- I understand that I may revoke this Authorization by sending written notice of my intent to revoke this Authorization to 3130 Broadway, Kansas City, MO 64111, Attention Privacy Officer.
- I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.
- A copy or facsimile of this Authorization shall be as valid as the original.

\_\_\_\_\_  
Signature of the individual or the individual's personal representative

\_\_\_\_\_  
Date

If signed by the individual's personal representative (e.g. a parent on behalf of a child), describe your authority to sign on behalf of the individual

**FRAUD NOTICE: For the states of AZ, AR, CA, CO, DE, DC, FL, IN, KS, KY, LA, MD, ME, NE, NM, OK, OR, PA, RI, TN, TX, VA, WA and WV, please refer to the following fraud notices:**

**Arizona Fraud Notice:** 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, Louisiana, Rhode Island, West Virginia Fraud Notice:** Any person who knowingly presents a false or fraudulent claim for payment of 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.

**California Fraud Notice:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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.

**Colorado Fraud Notice:** 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.

**Delaware Fraud Notice:** 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.

**DC Fraud Notice: 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.

**Florida Fraud Notice:** 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.

**Indiana Fraud Notice:** 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.

**Kansas, Nebraska, Oregon, Texas Fraud Notice:** Any person who, with intent to defraud or knowing that 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.

**Kentucky Fraud Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files 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 Fraud Notice:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine, Tennessee, Washington Fraud Notice:** 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.

**New Mexico Fraud Notice:** 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.

**Oklahoma Fraud Notice: 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.

**Pennsylvania Fraud Notice:** 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.

**Virginia Fraud Notice:** 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.