

Welcome to the



ATTENTION:

Assurity Accident Wellness claims can be filed 1 of 3 ways: Please keep in mind that any wellness claim that are submitted more than 12 months after the date of service will need to be submitted with the paper claim form and "proof of exam" documentation will need to be submitted with it (itemized billing showing name of patient, date of exam and type of exam).

Phone (Recommended): Assurity's Claims at Department at (800) 869-0355, Ext. 4484.

Online (Please note they have very detailed security questions and the processing time is longer) Customer Service Center on www.assurity.com

Paper (Not Recommended, takes longer): Form included below and should be emailed, faxed, or mailed to: jade@waregroupga.com

Fax: 217-954-0348

3808 W. Springfield Ave. • Suite C • Champaign, IL. 61822

Covered Wellness Exams under the Accident Policies

When filing for these benefits, please state that you received one of the following covered exams*:

Blood screening for triglycerides, cholesterol, HDL or LDL

Annual physical exams

Routine eye exams

Immunizations

*Pays once per date, up to two times per insured per calendar year, with a maximum of four times total per calendar year.

For assistance, please call:



Jade Wood

Claims Support & Office Manager

Jade@waregroupga.com

Phone: 855-535-4231 ext. 213

Fax: 217-954-0348

3808 W. Springfield Ave. Suite C
Champaign, IL. 61822

Office Hours: Mon-Thurs 8 am-4 pm, Fri 8 am-12 pm

<i>First, Middle, Last</i>		Policy/Certification no.	
<i>Street address</i>		<i>City</i>	<i>State</i> <i>Zip code +4</i>
Address			
Phone no. ()	Social Security no.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Policyowner's date of birth <i>MM/DD/YYYY</i>
1. Claimant's name _____		2. Date of birth _____ (<i>MM/DD/YYYY</i>)	
3. Relationship to Policyowner _____			
4. Name of medical provider _____		Phone no. ()	
Address of medical provider _____			
CLAIMANT INFORMATION	Your policy may not include all of the benefits listed below. Please consult your policy language for provisions and policy specific benefits. Some policies require proof of the amount charged for the services performed. This information can be obtained from the patient's healthcare provider(s) by requesting an itemized bill, HCFA 1500 non-hospital bill or a UB04 hospital bill. If proof of the amount charged is not provided when required by the policy, the claim may be delayed or denied. We will contact you if the itemized bill is required and not received.		
	5. Please indicate below which tests were performed. Date of test(s) _____ (<i>MM/DD/YYYY</i>) Amount charged \$ _____		
	<input type="checkbox"/> Annual physical	<input type="checkbox"/> Bone marrow biopsy and aspiration	<input type="checkbox"/> Serum protein electrophoresis (<i>blood test for myeloma</i>)
	<input type="checkbox"/> Pap smear	<input type="checkbox"/> PSA (<i>blood test for prostate cancer</i>)	<input type="checkbox"/> Serum cholesterol test to determine HDL and LDL levels
	<input type="checkbox"/> Chest X-ray	<input type="checkbox"/> Blood test for triglycerides	<input type="checkbox"/> CEA (<i>blood test for colon and cervical cancer screening</i>)
	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Flexible sigmoidoscopy	<input type="checkbox"/> CA 125 (<i>blood test for ovarian cancer</i>)
	<input type="checkbox"/> Mammography	<input type="checkbox"/> Stress test (<i>bicycle or treadmill</i>)	<input type="checkbox"/> CA 15-3 (<i>blood test for breast cancer</i>)
	<input type="checkbox"/> Breast ultrasound	<input type="checkbox"/> Fast blood glucose test	<input type="checkbox"/> CA 19-9 (<i>blood test for pancreatic cancer</i>)
	<input type="checkbox"/> Thermography	<input type="checkbox"/> Hemocult stool analysis	<input type="checkbox"/> Other cancer screening _____
	<input type="checkbox"/> Vision exam	<input type="checkbox"/> Biopsy for skin cancer	<input type="checkbox"/> Vaccinations/immunizations
<input type="checkbox"/> Hearing exam	<input type="checkbox"/> Dental exam (<i>must submit itemized bill</i>)	List vaccines/immunizations _____	
Claims can be faxed to (800) 869-0368 or mailed to Assurity at the address on the top of this form.			

FRAUD NOTICES

Unless specific state language is provided below for your state of residence, the following general fraud notice applies.

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 substantial civil penalty where and to the extent allowed by state law.

AL RESIDENTS: 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, DC, LA, MA, RI RESIDENTS: 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 RESIDENTS: 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 RESIDENTS: 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.

CO RESIDENTS: 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.

FL RESIDENTS: 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.

Continue to page 2 of this form.

IL RESIDENTS: 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 fraud or intentional misstatements of material fact commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

KS RESIDENTS: 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 may be a crime as determined by a court of law and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

KY RESIDENTS: 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.

MD RESIDENTS: 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.

ME, TN, WA RESIDENTS: 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.

MN RESIDENTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NC RESIDENTS: 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 may also be subject to a substantial civil penalty where and to the extent allowed by state law.

NH RESIDENTS: 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.

NJ RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM RESIDENTS: 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 RESIDENTS: 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.

OH RESIDENTS: 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.

OK RESIDENTS: 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.

OR RESIDENTS: Any person who knowingly and with intent to defraud an insurance company or any other person presents a false claim for payment of a loss or benefit may be guilty of insurance fraud and subject to civil fines and criminal penalties. If such misinformation is material to the content of the contract, relied upon by the insurer and either material to the risk assumed by the insurer or provided fraudulently, such action may also lead to denial of insurance benefits.

PA RESIDENTS: 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.

VA RESIDENTS: Any person who, with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT RESIDENTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Please consult your policy language for provisions.

I hereby acknowledge that I have read the applicable state fraud information above.

I hereby certify the statements contained above are complete and accurate to the best of my knowledge.

Date (MM/DD/YYYY)

Signature of Policyowner or legal representative

Printed name of person completing this form