

# Accident, Sickness, Heart Attack/Heart Disease/Stroke

Underwritten by: Manhattan Life Insurance Company  
Administered by: Bay Bridge Administrators LLC

## Claim Filing Instructions

### **Page 1 – Insured’s Statement of Claim:**

Must be completed each time you file a claim. Be sure to answer every question. If filing a claim due to accident/injury where a police report was filed, a copy of the police report must be included with claim.

### **Page 2 – Authorization**

Claimant or Authorized Representative must sign and date Authorization to allow physicians to release medical records to Bay Bridge Administrators, LLC

### **Pages 3 & 4 – Pre-existing Review Form**

If claim is being filed within the first two years of the policy, please complete this page with all physicians seen or medications taken in the past 24 months.

If provider fax numbers are known, please provide them in order to expedite this process. Please make certain authorization is signed and dated.

### **Pages 5 - Employer’s Statement**

If you are filing for total disability benefits under the accident policy, this form must be completed by your Employer representative.

### **Pages 6 & 7 - Physician’s Statement**

To be completed by your treating Physician. If treated in an emergency room, the admit and discharge summary may be submitted in lieu of this form.

**Please attach itemized billings, from your providers that include dates of service, diagnosis and procedure codes and corresponding Explanation of Benefits statement from the primary health insurance.**

**ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECESSARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.**

Return fully completed claim form and supporting documentation by mail or fax to:

Bay Bridge Administrators, LLC  
PO Box 161690  
Austin TX 78716  
512-275-9350 (fax)  
For questions call: 800-845-7519

**Claim Form for Accident, Heart Attack/ Heart Disease & Stroke**

**Underwritten by: Manhattan Life Insurance Company  
Administered by: Bay Bridge Administrators, LLC  
PO Box 161690  
Austin TX 78716  
800-845-7519**

**INSURED'S STATEMENT OF CLAIM**

Name of Insured:	Insured's Date of Birth:	Policy Number:
Street Address:		Phone Number (area code first):
Name of Claimant:	Claimant's Date of Birth:	Relationship to Insured:
Illness or Injury for which claim is being made:	Date of Accident or date Illness was first diagnosed:	Date you were first treated for your Illness or Injury:

Describe the onset and nature of your Illness or Injury:

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<p>Have you ever had the same or a similar condition in the past?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date _____</p>	<p>Treated by: _____</p> <p>Hospital: _____</p> <p style="padding-left: 40px;">Name Address</p> <p>Doctor: _____</p> <p style="padding-left: 40px;">Name Address</p>
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<p>Have you ever had the same or a similar condition in the past?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date _____</p>	<p>Treated by: _____</p> <p>Hospital: _____</p> <p style="padding-left: 40px;">Name Address</p> <p>Doctor: _____</p> <p style="padding-left: 40px;">Name Address</p>
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**Only complete the following portion if covered by and applying for Disability benefits under the optional rider on the Accident Policy**

6. Between what dates were you totally and continuously disabled? From \_\_\_\_\_ to \_\_\_\_\_
7. Between what dates were you partially disabled? From \_\_\_\_\_ to \_\_\_\_\_
8. If still disabled, when do expect to resume full duties? \_\_\_\_\_

**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.**

Signature of Insured \_\_\_\_\_  
Date \_\_\_\_\_

The above Statements are true to the best of my knowledge and belief

**AUTHORIZATION  
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I understand that my protected health information will be used for the purpose of evaluating my claim. I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize all health care professionals, pharmacies and pharmacy benefit managers to disclose my protected health information.
3. I authorize only designated staff of Bay Bridge Administrators, LLC. to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Bay Bridge Administrators, LLC. This revocation shall become effective on the date it is received by Bay Bridge Administrators, LLC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

\_\_\_\_\_

Signature	Print Name	Date
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I have legal authority\* under the laws of the State of \_\_\_\_\_ to make health care decisions on behalf of \_\_\_\_\_, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

\_\_\_\_\_

Name of Authorized Representative	Relationship to Applicant	Date
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Parent or Guardian\* A copy of the legal authority document must be on file with Bay Bridge Administrators, LLC

**If claim is being filed during the first two years of the policy, please complete the following and sign and date the authorization on the preceding page.**

Please list all physicians that treated the patient in the last 5 years:

Physician's Name:

Address:

Telephone Number:

Fax Number:

Approximate Date Consulted:

Diagnosis:

Physician's Name:

Address:

Telephone Number:

Fax Number:

Approximate Date Consulted:

Diagnosis:

Physician's Name:

Address:

Telephone Number:

Fax Number:

Approximate Date Consulted:

Diagnosis:

Physician's Name:

Address:

Telephone Number:

Fax Number:

Approximate Date Consulted:

Diagnosis:

Physician's Name:

Address:

Telephone Number:

Fax Number:

Approximate Date Consulted:

Diagnosis:

Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed

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 subject to prosecution and punishment for insurance fraud.

Return fully completed claim form and supporting documentation by mail or fax to:  
Bay Bridge Administrators, LLC  
PO Box 161690  
Austin TX 78716  
512-275-9350 (fax)  
For questions call: 800-845-7519

## Employer's Statement

To be completed by Employer		
Employee's Name:	SSN:	Date of Birth:
Date last worked or placed on light duty status: _____	Has Employee returned to regular work status? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Reason for stopping work: _____ _____	If yes, full-time date: _____ Part-time date: _____	
Is employee's job being held open?		
Name and Address of Employer:		
Employer Signature	Date Signed	
Printed Name and Title	Employer's Telephone Number	
E-mail address	Fax Number	

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 PO Box 161690  
 Austin TX 78716  
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## Physician's Statement

To be completed by the Medical Provider		
Claimant Name	Date of Birth	
Diagnosis	ICD-10 Code	Date of Diagnosis
Date Disability Commenced ___/___/___		
Is condition due to injury or sickness arising out of patient's employment? Yes    No	Dates of Treatment Date of first visit ___/___/___ Date of last visit ___/___/___	Frequency of treatment  Weekly Monthly Other
Has patient been hospital confined for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list name of hospital and dates:		
Has this patient been treated for this same or similar condition in the past prior to this occurrence? Yes    No		
If yes, Diagnosis:	Dates of Treatment	Name and address of Referring Physician:
Nature of Treatment – please describe course of treatment:		
Progress: (a) prognosis with reasonable estimate of return to work date		
Medical Provider's Name (Please Print)	Phone Number	Fax Number
Limitations (what the patient CANNOT do)		

Physical Impairment *as defined in Federal Dictionary of Occupational Titles)	<input type="checkbox"/> <b>Class I – No limitation of functional capacity; capable of heavy work *no restrictions (0-10%)</b> <input type="checkbox"/> <b>Class 2 – Medium manual activity *(15-30%)</b> <input type="checkbox"/> <b>Class 3 – Slight limitation of functional capacity; capable of light work * (35-55%)</b> <input type="checkbox"/> <b>Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)</b> <input type="checkbox"/> <b>Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)</b>	
Remarks:		
Medical Provider's Signature	Date Signed	
Name of Physician (Please Print)	Telephone Number	Fax Number
Mailing Address		

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## **FRAUD WARNING**

**Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West**

**Virginia:** 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.

**Colorado:** 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.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**Maine, Tennessee and Washington:** 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.

**Maryland:** 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.

**New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

**Oklahoma:** 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.

**Vermont:** 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.

**Virginia:** Any person who, with the 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 may have violated the state law.

**Pennsylvania and all other states:** 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.