



MEDICAL CLAIM FORM
 Claims Payment Services by Pan-American Life
 Attach Original Bills
 1-877-569-3075

MAIL FORM TO
 Pan-American Life Insurance Company
 P.O. Box 99007
 Lubbock, TX 79490-9007

INSTRUCTIONS FOR FILING YOUR CLAIMS ARE ON THE BACK OF THIS FORM. PLAN PARTICIPANT – COMPLETE THE FOLLOWING INFORMATION (Please Print)			
Group Name		Group No.	
Member Name	Date of Birth	Certificate Number or SSN	
Home Address	City	State	Zip Code
Is this a new address? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Patient's Name	Date of Birth	Relationship to member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
1. If the patient is a dependent child over age 19, he/she must be a full-time student to qualify for this benefit. In order to process your claim, we must receive your proof of fulltime student status for the period of medical expenses you submit.			
Name of School Attending			
School's Address	City	State	Zip Code
2. Is the claim associated with injuries resulting from an accident? When did it happen? A. _____ Where did it happen? B. _____ Provide details of accident and injuries:			
Does the accident or illness result from the patient's occupation? <input type="checkbox"/> YES <input type="checkbox"/> NO			
I HEREBY AUTHORIZE ANY DENTIST, PHYSICIAN, INSURANCE COMPANY, ORGANIZATION OR PLAN SPONSOR TO RELEASE ANY INFORMATION INCLUDING FULL COPIES OF THEIR RECORDS TO THE PAN-AMERICAN LIFE INSURANCE COMPANY OR ITS ADMINISTRATOR FOR ANY MEDICAL TREATMENT, SERVICES OR BENEFITS RENDERED OR PAYABLE TO ME ON MY BEHALF. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I HEREBY CERTIFY THAT THE FOREGOING ANSWERS ARE TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE. WHOEVER IN ANY DOCUMENT REQUIRED BY THE TITLE OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 MAKES ANY FALSE STATEMENT OR REPRESENTATION OF FACT SHALL BE FINED NOT MORE THAN \$10,000, OR IMPRISONED NOT MORE THAN FIVE YEARS OR BOTH.			
Plan Member's Signature		Date	
AUTHORIZATION OF PAYMENT			
ALL PAYMENTS OF MEDICAL INDEMNITY BENEFITS WILL BE PAID TO THE PROVIDER. TO AUTHORIZE PAYMENT DIRECTLY TO THE INSURED, PLEASE MAKE THAT AUTHORIZATION BY SIGNING HERE:			
Signed (Insured or authorized person)			
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.			

SCHEDULED BENEFIT MEDICAL PLAN CLAIM FORM

* To authorize the benefit payment to the insured, the claim form must be signed and sent to the Pan-American Life Insurance Company address below.

Claim form needs to be completed:

- The Plan Participant provides the basic information on the form and includes with the form;
- An original bill for services provided to include the diagnosis and date of service.
- If these charges are associated with an accident, details as to where the accident occurred, how it happened and when it happened, must be provided.
- UB04 form required for hospital stays.

If the form is not completed or a bill is not included, the claim cannot be processed.

The completed Claim Form and itemized bill should be mailed to Pan-American Life Insurance Company at:

P.O. Box 99007
Lubbock, TX 79490-9007

Pan-American Life Insurance Company will review the form for completeness:

- Has Pan-American Life received all of the appropriate medical documentation?
- Does Pan-American Life need additional information?
- Are the premiums paid current?
- Was the benefit eligible under the plan?
- Was the date of service within the eligibility period under the plan?
- Do we have the accident details (if necessary)?

If all information is received, the claim will be processed within 30 days.

**** NOTICE CONCERNING YOUR RIGHTS OF PRIVACY AS A CONSUMER ****

Pan-American Life Insurance Company collects nonpublic information about you from the following sources:

- Information we receive from you in applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

We do not disclose any nonpublic information about our customers or former customers to anyone, except as permitted by law.

We restrict access to your nonpublic personal information to those PALIC employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

FRAUD STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear on this claim form:

Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Fraud Warning for California Residents

For your protection, California law requires the following to appear on this claim form:

Any person who knowingly presents a 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.

Fraud Warning for Colorado Residents

For your protection, Colorado law requires the following to appear on this claim form:

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.

Fraud Notice for Louisiana, Maryland and Rhode Island.

For your protection, Louisiana, Maryland and Rhode Island law requires the following to appear on this claim form:

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 fines and confinement in prison.

Fraud Warning for the District of Columbia, Maine, Tennessee, Virginia and Washington Residents

For your protection, the District of Columbia, Maine, Tennessee, Virginia and Washington law requires the following to appear on this claim form:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

For your protection, Florida law requires the following to appear on this claim form:

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

Fraud Warning for Kansas Residents

For your protection, Kansas law requires the following to appear on this claim form:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information may be guilty of insurance fraud as determined by a court of law.

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

For your protection, New Jersey, New Mexico and Pennsylvania law requires the following to appear on this claim form:

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.

Fraud Statement for New York Residents

For your protection, New York law requires the following to appear on this claim form:

Any person who knowingly and with the 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.

Fraud Statement for Puerto Rico Residents

For your protection, Puerto Rico law requires the following to appear on this claim form:

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.