Aetna Accident Plan Benefits Request

Internal Use	
Category Code	VPCF
Office Key Code	039

Please call our Customer Service Center at 1-800-607-3366 between 8:00 AM and 6:00 PM if you have any questions about benefits or how to file your claim, or if you wish to appeal a decision.

The completion of this form does not guarantee payment.

A. Instructions for filling out this form

1. Please check the box(es) that best describes your claim:

Benefit	Check Box	Benefit	Check Box	Benefit	Check Box
*Accidental Death	☐	Dislocations – Closed Reduction	☐	Pain Management (Epidural Anesthesia)	☐
Accidental Dismemberment	☐	Dislocations – Open Reduction	☐	Paralysis	☐
Accident Follow-up	☐	Emergency Room	☐	Physician's Office or Urgent Care Center	☐
Ground Ambulance	☐	Eye Injury	☐	Posttraumatic Stress Disorder (PTSD)	☐
Air Ambulance	☐	Fractures - Closed Reduction	☐	Prescription Drugs	☐
Animal Bite Treatment	☐	Fractures - Open Reduction	☐	Prosthetic Device/Artificial Limb	☐
Appliances (for mobility)	☐	Gunshot Wound	☐	Rehabilitation Unit - Daily	☐
Blood/Plasma/Platelets	☐	Home and Vehicle Alteration	☐	Service Dog	☐
Brain Injury	☐	Hospital Stay - Admission	☐	Surgery (with repair)	☐
Burns	☐	Hospital Stay – Daily	☐	Surgery (with no repair)	☐
Burn Skin Graft	☐	ICU – Daily	☐	Tendon/Ligament/Rotator Cuff	☐
	☐	Laceration	☐	Therapy Services	☐
Chiropractic Treatment and Alternative Therapy	☐	Lodging - provide lodging date	☐	Torn Knee Cartilage	☐
Coma/Persistent Vegetative State (PVS)	☐	Medical Imaging	☐	Transportation	☐
Concussion	☐	Observation Unit	☐	Walk-in Clinic/Telemedicine	☐
Dental Treatment	☐	Organized Sports	☐	X-ray/Lab	☐

*Please provide original death certificate and complete Sections B, C, E, F, G, K and J.

2. Complete items in **Section B & C** in full.
3. Complete **Section D** if the accident occurred on-job and provide copies of the employer incident report.
4. If you had an off-job accident/injury, please provide copies of the incident and/or police report.
5. Complete **Section H** if you had any transportation or lodging. Also, provide accommodation receipts and mileage to and from the treating facility.
6. Complete **Section I** if you had an organized sports injury.
7. Complete and sign **Section L**.
8. Have Physician complete **Sections J & K** in full.
9. Please provide an itemized bill or UB04 form from the hospital.
   - For service dog benefit provide supporting documentation from your doctor along with receipts from ADI or IGDF.
   - For prescription drug benefit provider pharmacy receipts.
   - For home and vehicle alteration benefits provide alteration receipts.
   - Any other documents to support your claim.
10. Retain copies of your bills for your record.
11. Send the completed benefits request and the bills to:

Aetna Voluntary Plans
PO Box 14079
Lexington, KY 40512-4079

Fax to: 1-859-455-8650
Phone: 1-800-607-3366

NOTE: INCOMPLETE CLAIM FORMS WILL DELAY THE PROCESSING OF THE CLAIM.

B. Employee and Patient Information (to be completed by Employee)

1. Employee's Name/First Middle Last		
2. Employee's address (include ZIP code) ☐ Check if address is new		
3. Employee's e-mail	4. Employee's Policy/ Group Number	5. Employee's W ID # or SSN
6. Employee's Birthdate (MM/DD/YYYY) / /	7. Employee's Gender ☐ Male ☐ Female	8. Daytime phone number ( ) -
9. Occupation	10. Employer Name	11. Contact number ( ) -
12. Patient's name (if not employee)		13. Patient's W ID# or SSN (if different than above)
14. Patient's address (if different than employee)		
15. Patient's Birthdate (MM/DD/YYYY) / /	16. Patient's Gender (if not employee) ☐ Male ☐ Female	17. Patient's relationship to policy/certificate holder ☐ Self ☐ Spouse ☐ Child ☐ Other

C. Accident Details

1. Date of accident (MM/DD/YYYY) / / Time: ☐ a.m. ☐ p.m.	2. Where did it happen? ☐ On-Job ☐ Off-Job	3. Is Accident related to employment? ☐ Yes ☐ No
4. Tell us exactly how your accident/injury happened.		
5. Has similar condition happened in the past? ☐ Yes ☐ No If **Yes**, state when and where.		

D. On-Job Employer Information (complete only if accident occurred On-Job)

1. Supervisor's name	2. Supervisor's phone number ( ) -	3. Date (MM/DD/YYYY) / /

E. Information About the Deceased

1. Deceased's Name (last, first, middle initial)		2. If deceased is known by any other name, provide Name (last, first, middle initial)			
3. Relationship to Employee	4. Social Security Number	5. Birthdate (MM/DD/YYYY)	6. Date of Death (MM/DD/YYYY)	7. Age	8. Gender ☐ Male ☐ Female
9. Last Residence: Street		10. City		11. State	12. ZIP

F. Information About the Beneficiary(ies)

	1.	2.	3.
1. Name			
2. Street			
3. City			
4. State (use 2-digit code)			
5. Zip			
6. Social Security Number			
7. Relationship to Employee			
8. Birthdate (MM/DD/YYYY)			
9. Main Contact Number			
10. Has benefit/ownership been assigned? ☐ No ☐ Yes	11. If Yes, to whom? (send copy of assignment)	12. Assignee's Social Security Number	

G. Benefit Distribution Instructions

1. Return the benefit payment directly to:
   ☐ Beneficiary ☐ Other _____

H. Transportation and Lodging Benefit – Please complete the following information if you are filing a claim for transportation and/or lodging reimbursement. You will also need to send in any hotel/motel receipts and mileage information for the treating facility.

1. **Transportation**

Date (MM/DD/YYYY)	Name of treating facility	Address	Mileage One way
/ /			
/ /			
/ /			

2. **Lodging**

Date (MM/DD/YYYY)	Name of hotel/motel	Address	Mileage One way
/ / to / /			
/ / to / /			
/ / to / /			

I. Organized Sports Benefit

1. Was your accident related to an organized sport?
   ☐ Yes ☐ No
2. Name of sport. _____
3. Name of sporting organization. _____

J. Physician's Statement (to be completed by Physician)

1. Name and address of facility where services rendered	2. Date of service (MM/DD/YYYY) / /

3. For services related to hospitalization, give hospitalization dates (MM/DD/YYYY)
Admit Date: / / Discharge Date: / /

4. Diagnosis code(s) or ICDP(s)

1.	2.	3	4.	5.
6.	7.	8.	9.	10.

5. Describe nature of accident, illness or injury

6. Was an x-ray taken? ☐ Yes ☐ No Date of x-ray:	7. Hospital stay type ☐ Inpatient ☐ Outpatient ☐ Observation

8. Has patient had similar condition?
☐ Yes ☐ No If Yes, state when and describe.

9. Any other diseases or illness affecting patient?
☐ Yes ☐ No If Yes, describe.

10. Nature of surgical procedure, if any (describe fully). Provide CPT's.

K. Physician Verification

1. Print full name		2. Tax identification number
3. Signature	4. Date (MM/DD/YYYY) / /	5. Phone number ( ) -
6. Street address, city, state and ZIP code		

L. Authorization to Release Information

For the purpose of evaluating and administering my claim for benefits, I hereby authorize the disclosure of information concerning health care advice, treatment or supplies (including that related to mental illness and HIV) provided to me and, if applicable, my dependents, to Aetna Life Insurance Company (Aetna) and its affiliates and authorized representatives. If applicable, I also authorize the disclosure of information concerning my employment. This authorization is valid for the term of the policy or certificate under which the claim has been submitted. I know that I may request a copy of this authorization, and I agree that a copy of this authorization is as valid as the original.

Signature	Printed name	Date (MM/DD/YYYY) / /

If the person signing is the legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative, please sign and print your name and indicate the relationship here.

Signature	Printed name	Relationship

Misrepresentation Section

Any person who knowingly and with intent to injure, defraud or deceive 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.

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 9% on the total amount payable or the face amount if payments are to made in installments until the total payment or the first installment is paid.

FRAUD WARNINGS BY STATE

NOTICE IN ALABAMA: 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.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN ARIZONA: 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.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN 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.

NOTICE IN DISTRICT OF COLUMBIA: FRAUD NOTICE: 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.

NOTICE IN FLORIDA: 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.

NOTICE IN 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.

NOTICE IN NEW HAMPSHIRE: 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, as provided in RSA 638.20.

NOTICE IN OHIO: 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.

NOTICE IN OREGON: Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE IN PENNSYLVANIA: 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.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN 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 include imprisonment, fines and denial of insurance benefits. NOTICE IN TEXAS: 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.

NOTICE IN WEST VIRGINIA AND RHODE ISLAND: 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.

NOTICE IN NEW YORK: 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.

Signature:	Date (MM/DD/YYYY):

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ તના ખર્ચ ના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇ કાડપર રહેલ નંબર પર કૉલ કરવો.
Hindi	बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, अपने आइड काडर् पर दए नंबर पर कॉल कर।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိဉ်လၢ်ဘူဉ်လၢ်စ့ၤ လၢနဂီၢ်အဂီၢ်, ကိးနီဉ်ဂံၢ် လၢအအိဉ် ဖဲန ID အဖီခိဉ်နှဉ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ເຂົ້າເຖິງບໍລິການພາສາທີ່ບເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបនសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមរទូរសព្ទកាន់លេខដែលមាននលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílį́įgo nanitinígíí bee nééhoʼdólzinígíí béésh bee hane'í biká'ígíí áajįʼ hólne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆ ਪੰਜਾਬੀ ਸੇਵਾਵਾ ਦੀ ਵਰਤੋ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܐܢ ܚܫܟܐ ܬܠܘܢ ܥܠ ܝܠܦܢܘܬܐ ܕܫܪܬܐ ܒܠܫܢ ܡܫܬܐܠܘ، ܩܪܘܢ ܡܢܝܢ ܥܠ ܦܬܩܐ ܕܗܘܝܬܐ ܕܝܠܘܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	**หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน**
Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.