Welcome to the

WARE GROUP
GENERAL AGENCIES

APL WELLNESS CLAIMS

APL Wellness benefit claims can be filed 1 of 2 ways:

1. 1) Call-in: You can reach out to Jenni Medler at 217-607-0742 Ext 210 and she can assist in completing the claim form on your behalf, over the phone. If you receive a voicemail with calling, please leave a message as Jenni may be assisting another client.
    - When using this option, please have all information ready when calling in:
        - Insured's Name, Date of Birth, SS#, Address
        - Patient's Name, Date of Birth, SS#
        - Type of test that was performed and date of test
        - Name and contact number of Physician that performed test

2) Paper Form: Once you complete the attached form, you can submit using one of the following options:

- You can mail them to 3808 W Springfield Ave. Suite C, Champaign, IL 61822
- You can email them to admin@waregroupga.com
- You can fax them to 217-954-0348

The last page of this packet includes a direct deposit form that will need to be completed if you prefer your benefits to be paid directly to your account, if this is not completed, benefits will be paid out via paper check to your mailing address. A voided check or deposit slip is not required for direct deposit as long as that section is filled out in full.

Please keep in mind that Jenni can take your bank account information over the phone at time of claim, when using the call-in option.

Covered wellness exam under the Accident Illness policies are as follows:
Routine physical exam, Dental exam, Eye exam, Epworth sleepiness scale, Hemoglobin A1c, Baseline testing for concussions, Bone density screening, Stress test or weight reduction program, or any additional generally accepted medically accepted outpatient

For assistance, please call:

Jenni Medler

Administrative Assistant
admin@waregroupga.com
Phone: 217-607-0742 ext. 210
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

APL Claims
P.O. Box 248950
Oklahoma City, OK 73124-8950
Phone: 800-256-8606
Fax: 877-365-9423
www.ampublic.com

Wellness Claim Form

File claims using the Online Service Center (OSC) for faster payments, claim status updates, direct deposit and more.
Sign up or log in now!

Instructions

For the Insured or Patient

- Complete the Statement of Insured (Sections A through E) as applicable to your claim.
- Completing Section F is not required; however, completing this section will reduce delays in processing should we need to request additional information regarding your claim.

STATEMENT OF INSURED

Section A - About the Insured

First Name	MI	Last Name	Suffix

Date of Birth	Social Security Number **or** Policy Number(s)

Address	City	State	Zip Code

Home Phone Number	Cell Phone Number	E-mail Address

Section B – About the Patient

First Name	MI	Last Name	Suffix	Date of Birth

Section C – Benefits Claimed

Select which test(s) or health exam(s) were performed. Refer to your Policy/Certificate for benefits covered under your plan.

Diagnostic Imaging Studies

Test Performed	Date of Service	Test Performed	Date of Service
☐ Abdominal aortic aneurysm ultrasonography		☐ Echocardiogram	
☐ Bone density screening		☐ Electrocardiogram	
☐ Breast ultrasound		☐ Epworth sleepiness scale	
☐ Carotid doppler		☐ Flexible sigmoidoscopy	
☐ Chest x-ray		☐ Magnetic resonance imaging (MRI)	
☐ Colonoscopy		☐ Mammogram	
☐ Computerized axial tomography (CAT scan)		☐ Neuroimaging study	
☐ Computerized tomography scan (CT scan)		☐ Positron emission tomography (PET) Scan	
☐ CT angiography		☐ Stress test	
☐ Digital infrared thermal imaging of breast		☐ Testicular ultrasound	
☐ Doppler ultrasound		☐ Thermography	
☐ Double contrast barium enema		☐	

Pathology/Laboratory Services

Test Performed	Date of Service	Test Performed	Date of Service
☐ Biopsy for cancer		☐ Fasting blood glucose test	
☐ Bone marrow aspiration		☐ Hemoccult stool analysis	
☐ Bone marrow biopsy		☐ Hemoglobin a1c	

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Test Performed	Date of Service	Test Performed	Date of Service
☐ BRCA genetic test		☐ Metabolic lipid panel	
☐ CA 125 blood test for ovarian cancer		☐ Pap smear (including ThinPrep)	
☐ CA 15-3 blood test for breast cancer		☐ PSA Test	
☐ CA 19-9 blood test for pancreatic cancer		☐ Serum protein electrophoresis	
☐ CEA blood test for colon cancer			
☐ Lymphocyte genome sensitivity (LGS) test			

Exams

Test Performed	Date of Service	Test Performed	Date of Service
☐ Baseline testing for concussions		☐ Skin cancer screening	
☐ Routine dental exam		☐ Smoking cessation program	
☐ Routine physical		☐ Weight reduction program	
☐ Routine vision exam			

Other Wellness Test(s)

Test Performed	Date of Service

Genetic Testing

Test Performed	Date of Service

Vaccines for prevention of a Critical Illness

Test Performed	Date of Service	Test Performed	Date of Service

Section D - About your Medical Provider

Physician's Name	Physician's Contact Number

Acknowledgement - Your signature is required for benefit consideration

I hereby certify the answers I have provided in the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice included in this claim form.

Signature of Insured/Beneficiary _____ Date Signed _____

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Section E – Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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.

Alaska - A 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.

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.

Arkansas, District of Columbia, Louisiana, 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.

California and Texas - For your protection California and Texas 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 - 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, Idaho and 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.

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.

Indiana - 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.

Kentucky - 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.

Maine, Tennessee, Virginia 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.

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

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.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - 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.

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.

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.

Puerto Rico - 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 by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] 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.

Wellness Claim Form

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Section F - Authorization to Disclose Information Including Protected Health Information

The purpose of this form is to allow American Public Life Insurance Company (APL), or business partners acting on behalf of APL in the administration of APL products and services to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, APL may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my Customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing APL who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities or their business associates; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. APL will only disclose any data collected pursuant to this authorization as necessary for legitimate business purposes, and only to the extent allowed by law.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which I may have been treated.

I understand APL may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or an inability to pay benefits under my policy if my failure to sign results in APL not having enough information to process my benefits. I understand I may revoke this authorization at any time by writing to APL, P.O. Box 248950, Oklahoma City, OK 73124-8950 or by calling 800-256-8606. I understand that my right to revoke this authorization is limited to the extent that: APL has acted in reliance on the authorization; or the law provides APL with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations. In addition to the types of information described above, I also authorize APL to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to APL.

For health insurance coverage, this authorization will expire 24 months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire 24 months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

APL Policy Number	Printed Name of Patient	Patient's Date of Birth

Signature (*Patient*) or Personal Representative (*if applicable*)	Date Signed

Relationship of Personal Representative to Patient (if applicable)
If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

APL Claims Department
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DIRECT DEPOSIT AUTHORIZATION

I hereby authorize American Public Life Insurance Company (APL) to initiate credit entries, at the bank named below, for the purpose of receiving APL insurance claim payments, to my account indicated below. I also authorize APL to debit my account for any deposits made in error. I authorize and request the bank named below to accept any credit entries by APL to my account indicated below. I acknowledge that the origination of ACH transaction to my account must comply with the provisions of U.S. Law.

Policyholder Information

Name (Last, First, Middle Initial)		Social Security Number
Address (Street, City, State, & Zip Code)	Cell Phone Number	Home Phone Number
Employer		

Account Information (VOIDED Check or Deposit Slip Must Be Attached)

Bank Name	Bank Address
Routing Number	
Account Number to Credit	Account Type

This authorization is to remain in effect until APL has received written notification from me of its termination to afford APL reasonable opportunity to act on it. APL reserves the right to discontinue your participation in the Direct Deposit of Insurance Claim Payments services at any time at its sole discretion. This authorization applies to benefits payable under all insurance policies held with American Public Life Insurance Company (APL).

NOTE: THIS FORM MUST BE RECEIVED AND PROCESSED BEFORE A PREAUTHORIZED PAYMENT CAN BE MADE.

Signature:_____ Date:_____