Welcome to the

WARE GROUP
GENERAL AGENCIES

APL HOSPITAL INDEMNITY CLAIMS

.
To collect on the APL Hospitalization coverage, please complete the attached claim form, Please be sure to sign page 1 and 3 of the claim form as this will not be processed without your signature. Please provide office notes or documentation such as a UB-04 Form or HCFA-1500 Form that show anything that pertains to your Hospital Confinement.

When gathering this documentation above, I highly recommend asking your medical provider's billing department for a UB04 Form or HCFA 1500 Form. These universal billing forms will have procedures & diagnosis indications listed and should provide the claims analyst with what is needed to process the claim. It is important to provide information on both services received but also diagnosis. If a UB-04 Form or HCFA-1500 form cannot be obtained please request from your provider's billing department itemized billing that includes procedure codes, diagnosis indicators, billed amounts, room/board charges and dates of confinement. Please note that an EOB from your health insurance provider is not a substitute for itemized billing from your medical care provider.

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.

Once you're able to complete and sign the claim forms, there are 3 ways to submit:
You can mail them to 3808 W Springfield Ave. Suite C, Champaign, IL 61822
You can email them to jade@waregroupga.com
You can fax them to 217-954-0348

We will then forward this on to an examiner and follow up with them in 1 week to check on the status.

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

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

Hospital Indemnity and Everyday Solutions 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 B) as applicable to your claim.
- Completing Section D is not required; however, completing this section will reduce delays in processing should we need to request additional information regarding your claim.
- An itemized bill with diagnosis from the provider must accompany the completed Statement of Insured
- Your signature is required for benefit consideration

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

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

Hospital Indemnity and Everyday Solutions Claim Form

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

Section C – 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.

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

Hospital Indemnity and Everyday Solutions Claim Form

Section D - 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
P.O. Box 248950
Oklahoma City, OK 73124-8950

Phone: 800-256-8606
Fax: 877-365-9423
www.ampublic.com

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:_____