SNI ACCIDENT/ACCIDENTAL DEATH & DISMEMBERMENT CLAIM FORM

Please read the important information below:

- **Please be sure your Member ID is written on the form.**
- **The form must be completed and signed by the Primary Member or Beneficiary.**
- **The HIPAA Authorization to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission, so that we can contact your medical provider on your behalf if additional information is needed.**
- **Attach itemized bills to the request. For faster processing, ask your medical provider to print an itemized bill on a UB-04 form (for hospital expenses) or on a CMS 1500/HCFA form (for doctor's expenses).**

An itemized bill is a statement that indicates:

1. **The date(s) of treatment**
2. **The type(s) of service**
3. **The diagnosis**
4. **The medical provider's name and address**
5. **The individual charge for each expense**

Processing delays may result if you do not provide the above information.

Please send the completed form, signed authorization, itemized bills, other liable third party payment or denial statements, physician completed dismemberment form (if applicable), and death certificate (if applicable) to:

Sovereign Nations Insurance
PO Box 1810
Draper, UT 84020
OR Fax to: 801-274-8900
OR Email to:
customerservice@sniprotect.com

- **You must send complete proof of loss (completed and signed form and itemized bills) within 60 days of the accident. Additional bills related to the accident should be sent within 60 days of treatment.**
- **The SNI Accident program requires that the first treatment or service must occur within 60 days of the accident and all subsequent treatments must occur within 12 months of the accident.**
- **If you have another insurance plan or primary insurance coverage, please send us a copy of their payment or denial statement.**
- **Please indicate which bills have been paid by you. If you prefer payment to go directly to the medical provider, please complete and sign the authorization at the bottom of the form.**
- **A form only needs to be completed at the beginning of treatment for each accident. Additional bills or follow-up treatment should indicate your Member ID and date of accident.**

For assistance, please contact our Customer Service Department 844-200-8820

SNI ACCIDENT CLAIM FORM

TO BE COMPLETED BY THE MEMBER

Primary Member Information

Name of Member:		Member ID#:	
DOB:	Phone:	Email: (Please provide for faster service)	
Street:	City:	State:	ZIP:

Patient Information (Please fill out if different than Primary Member)

Name:		Relationship to Primary:
DOB:	Gender: Male Female	Email: (If different than the Primary)

Accident Information

Date of Accident	Time of Accident AM PM	Location of Accident (Location, City, and State)

Description of Accident:

Due to this injury, were or are you currently totally disabled? Yes No

Did this accident occur while playing in an Intercollegiate or Professional Sport? Yes No
If yes, please indicate the type of sport:

Are you self employed? Yes No	Was this a work related accident/injury? Yes No

If yes, was this filed with Workers' Compensation? Yes No
If no, please explain why:

Is this request for a reinjury or complication of an injury caused by a condition that existed before the accident? Yes No
If yes, please explain:

Was death a result of this injury? Yes No	If yes please submit the certified death certificate

Other Related Expenses

Is the Patient a member of any other insurance plan for expenses related to this accident? If yes, please provide the information needed below. Yes No

Member Name:	Insurance Carrier Name:	Carrier Phone Number:
Policy Number:	Effective Date:	Termination Date (if applicable):

I HEREBY AUTHORIZE Sovereign Nations Insurance to pay bills in connection with this claim directly to the Hospital or Other Medical Provider as indicated below. I understand that I am financially responsible to the Hospital or Other Medical Provider for charges not covered under this plan.

I understand that this information will be used by Sovereign Nations Insurance and authorized third parties for the purpose of evaluating my claim. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of the authorization upon request.

Member Signature **Hospital or Other Medical Provider Name**

Print Name **Date** **Hospital or Other Medical Provider Name**

DISMEMBERMENT FORM

MUST BE COMPLETED BY THE PHYSICIAN FOR DISMEMBERMENT CLAIMS ONLY

Physician's certificate

Patients Name:	DOB:

Please provide your diagnosis.

Please give full description of the injury.

On what date did the accident occur?	On what date did the patient first consult you for this injury?

Was the patient treated by other physicians for the injury? Yes No
If so, please list the names and addresses if known

Name: *Name:*

Address: *Address:*

If surgery was performed, please indicate the type of surgery performed.	Date Performed:

Please list the name and address of the hospital where the surgery was performed if known.

Were there any complications following surgery? If so, please explain in detail.

Was the dismemberment or loss a direct result of injuries sustained in an accident, independent of all causes? If not, please explain in detail. Yes No

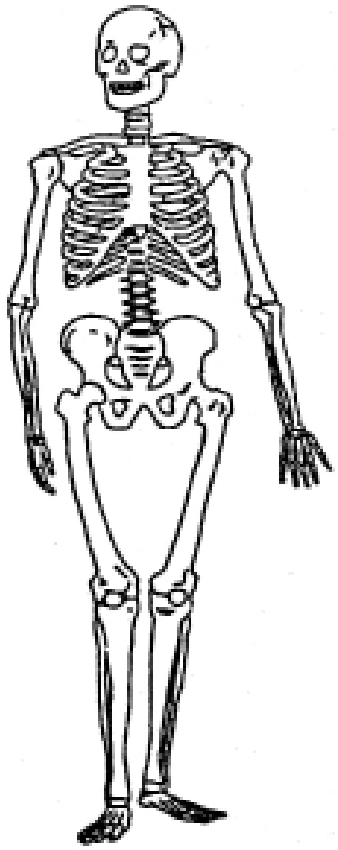
If this claim is for dismemberment, please mark the exact point of amputation on the diagram.

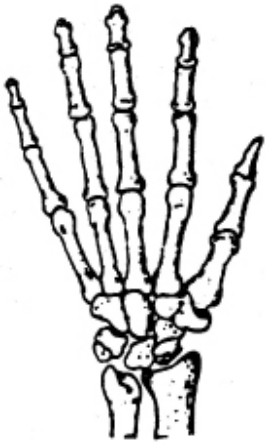
If this claim is for loss of sight, what is the patient's visual acuity? Is the loss total and permanent? Is the loss due to the accident? Please explain in detail. Can the vision be corrected with either surgery or lenses. If so, to what degree?

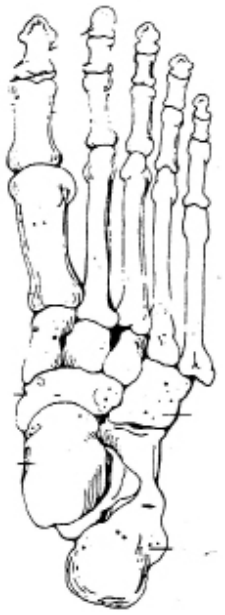
If this claim is for loss of speech or hearing, please attach examination and laboratory results.

At the time of the injury, had the patient been diagnosed for any specific disease, illness or old injuries? If so, please list the diagnosis.

If this claim is for loss of use, please identify the areas affected on the diagram.







CONTINUE FORM ON NEXT PAGE

CONTINUED FORM FROM PREVIOUS PAGE

What period was the patient continuously disabled?
From: *Through:*

Would you consider the injury to be work-related? Yes No
If so, please explain in detail.

Have you prepared a report of this nature for any other insurance company? Yes No
If so, please provide name and address.
Name:

Address:

Remarks:

Physician Information

Physicians Name:		Specialty:	
Tax ID:	Phone:	Email:	
Street:	City:	State:	ZIP:

Physician Signature **Print Name** **Date**

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by SNI for purposes of obtaining information necessary to process a claim for coverage.

Member ID #:	

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, health share ministry, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Sovereign Nations Insurance or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for verifying eligibility or claims processing and information provided to any affiliated third party on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for coverage. Revocation requests must be sent in writing to the attention of the Claims Processor.

I understand that Sovereign Nations Insurance may condition this claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by SNI in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Member **Date of Birth**

Signature of Member **Date**

(Print Please) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Member

Signature of Authorized Representative or Next of Kin **Date**