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SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Select Benefits
Mailing Address: Symetra Select Benefits
PO Box 440 | Ashland, WI 54806
Overnight deliveries to: 118 3rd St E | Ashland, WI 54806
Phone 1-800-497-3699 | Fax (715) 682-5919

CLAIM FORM
Select Benefits

TO BE COMPLETED BY CERTIFICATEHOLDER *(See attached notice)*

Full name of Certificateholder (Please print) | Insured ID Number (found on card)

Address (Street, city, state, zip code)

Patient's name and address (Complete only if Patient is someone other than Certificateholder)

Patient's relationship to Certificateholder
☐ Spouse ☐ Child *birth date*_____ ☐ Other_____

Name of Policyholder | Group number

When seeing a Provider, you have two options for filing a claim.

Option 1: Provider Submission – The more common way to submit a claim for benefits to Symetra is to present your Symetra Select Benefits ID card to your Provider. Ask your Provider to accept your assignment of benefits at the time of service and to bill our administrative office, Symetra Select Benefits, directly.

Note: The Provider is under no obligation to accept an assignment.

Option 2: Certificateholder Submission – If you paid your Provider at the time of service, or you did not assign your benefits, you may submit a claim via this form. In order to receive your benefits, you must:

1. Complete this form in its entirety. Return it to Symetra Select Benefits along with a copy of your itemized bill for services or a claim form given to you by your Provider (doctor's office, clinic, hospital or similar).

   To be accepted as proof of loss/claim, an itemized bill or claim form *must contain all* of the following information:
   ☐ Patient name
   ☐ Provider name and address
   ☐ Diagnosis or ICD-10 code(s) (description of the medical condition)
   ☐ Procedure or CPT or revenue codes (indicates the services rendered)
   ☐ Charges
   ☐ Date(s) of service

2. An Authorization for Release of Medical Information form (Authorization) may be required for our use in the event we deem it necessary to contact the Provider to obtain proof of loss/claim due to incomplete or illegible information or other reason. If you receive an Authorization, it is because we do not have a current form on file for the Patient. Please sign and return the Authorization (if enclosed) with your proof of loss/claim.

Benefits are subject to eligibility at the time of service and to any coverage limitations that may apply. Proof of loss/claim satisfactory to Symetra Life Insurance Company is required before payment of benefits. Benefits can only be determined after receipt of proof of loss/claim; this form is not a guarantee of payment.

I, the undersigned Certificateholder, do certify that the information I have given is true, correct, and complete to the best of my knowledge. Further, I certify that I have read the attached fraud notice.

Signature of Certificateholder | Date

CLAIM FORM FRAUD WARNINGS

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: 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.

AR, LA, RI, WV: 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.

AZ: 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.

CA: For your protection California law requires the following to appear hereon: 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.

CO: 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.

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

DC: 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.

FL: 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.

ME: 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.

MD: 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.

NH: 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.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: The following applies to health insurance only: 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.

OK: 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.

PA: 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.

TN, VA, WA: 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.

TX: 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.

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Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may:
1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage;
3) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; and
4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient