CANOPY INSURANCE
ROOTED IN ALABAMA

Group Accident Claim Form

Mail to: Canopy Insurance Claims Processing, PO Box 3187, Tuscaloosa, AL 35403
Email to: Claims@CanopyInsuranceCorp.com
Fax to: 205-409-2527

Please submit this form via mail, email, or fax. If you have additional documentation that relates to the claim other than the documents defined below, please submit them for review of additional benefits. If you have any questions or would like to check the status of your claim, please call our **Customer Service Department at 205-451-0444.**
Note: All injuries listed may not be covered by your policy. Refer to your certificate of coverage for benefits available under your plan.

GROUP INFORMATION

Group Name: _____ **Group Number:** _____

Group Contact Information (This is generally someone in Human Resources or Administration)

Contact Name: _____ **Email:** _____ **Phone Number:** _____

PRIMARY INSURED INFORMATION

Full Name: _____ **DOB:** _____ **SSN:** _____ **Member ID:** _____

Mailing Address: _____
Street *City* *State* *Zip*

Phone Number: _____ **Email:** _____

CLAIMANT INFORMATION

Full Name: _____ **DOB:** _____ **Gender:** _____ **Relationship:** _____

Phone Number: _____ **Email:** _____ **Date of Death* (if applicable):** _____
*Submit Death Certificate.

CLAIM INFORMATION

PLEASE CHECK THE BOXES THAT ACCURATELY DESCRIBE THIS ACCIDENT CLAIM. ☐ **First Claim** ☐ **Continued Claim**
If you have incurred an accident, please check the boxes that best describe the event and resulting injuries.
Submit documentation that indicates the physician, date(s) of service, patient name, and medical reports, and please also include itemized invoices.

ACCIDENT INFORMATION - Attach a separate piece of paper if additional space if needed.

Date (mm/dd/yyyy): _____ **Time:** _____ ☐ am ☐ pm **Work Related:** ☐ Yes ☐ No **Location:** _____

Is there a police or an employer incident report? (If Yes, please submit.) ☐ Yes ☐ No

Please describe the accident and resulting injuries. _____

INJURY INFORMATION - Attach a separate piece of paper if additional space if needed.

Did Claimant seek medical attention? ☐ Yes ☐ No

- ☐ Urgent Care Date(s): _____
- ☐ Hospital ER Date(s): _____
- ☐ Doctor's Office Date(s): _____
- ☐ Other: _____ Date(s): _____

Did Claimant undergo any of the following? ☐ Yes ☐ No

- ☐ X-Ray Date(s): _____
- ☐ MRI Date(s): _____
- ☐ CT Scan Date(s): _____
- ☐ Other: _____ Date(s): _____

Was Claimant admitted to hospital? ☐ Yes ☐ No

Name of Hospital: _____ Date Admitted: _____ Date Discharged: _____

Was Claimant transported by ambulance (air, ground, or water)? ☐ Yes ☐ No If Yes, please describe: _____

Did Claimant's injury require surgery? ☐ Yes ☐ No If Yes, please describe: _____

Please check all boxes that apply regarding the Claimant's injuries.

- ☐ Fracture
- ☐ Disclocation
- ☐ Burn
- ☐ Concussion
- ☐ Broken Teeth
- ☐ Coma
- ☐ Eye Injury
- ☐ Laceration
- ☐ Gunshot Wound
- ☐ Paralysis
- ☐ Dismemberment
- ☐ Other (please describe) _____

Did Claimant seek follow-up treatment from medical professional (doctor, physical/occupational therapist, chiropractor, etc.)? ☐ Yes ☐ No

Did Claimant or an immediate family member travel to access care for the Claimant? ☐ Yes ☐ No
If Yes, please provide traveler's name, relation to Claimant, home address, medical facility travelled to, and date(s) travelled.
If lodging away from home was sought, please provide itemized receipt(s).

HOSPITAL SICKNESS RIDER - Please only complete if filing a claim under the Hospital Sickness Rider

Condition for which claim is being filed: _____ **Date Symptoms First Appeared:** _____

AUTHORIZATION

I authorize any third party to release any and all medical and non-medical information about me to Canopy Insurance Corporation or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I understand that information obtained by this authorization is to determine eligibility for insurance or eligibility for benefits under an existing plan. Canopy will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I may request and receive a copy of this authorization, and agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim.

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.

Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose.

_____ _____
Signature of Primary Insured or Power of Attorney (attach Power of Attorney, if applicable) Date

_____ _____
Signature of Claimant (if different than Primary Insured) or Power of Attorney (attach Power of Attorney, if applicable) Date