

Brella

Fidelity Security Life Insurance Company®
Administered by Brella Services Inc.
Attn: CLAIMS
2093 Philadelphia Pike #2496
Claymont, DE 19703

With Brella, it's easy to file a claim.

It just takes a few minutes to submit a claim online at joinbrella.com or through the Brella app. You'll enjoy faster processing time and we'll send you updates on your claim electronically.

If you'd rather not file a claim online, you can use this paper form to submit your claim to us by mail or fax.

If you have questions, call your Brella Concierge at 1 (888) 300-5382.

Before you submit your claim

Double check that you are submitting a claim for a covered condition. You can look up your condition by logging in to your Brella account or call your Brella Concierge at the number above.

Also, be sure to gather any documentation that proves that you were diagnosed with this condition by a licensed medical provider. Taking these steps before you submit your claim can help you avoid a delayed or denied claim.

How to use this form

Please read all instructions and be sure to completely fill out the form. If you provide an incomplete claims submission, this could delay the processing of your claim.

- Do not write on the form except as instructed.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Sign, date, and fax or mail your completed claim submission, along with your supporting documentation, to the Brella fax number/address shown below.

In addition to the claim form, please submit four supporting documents that confirm your claim, including the condition(s) you had and the date you were diagnosed. If you don't have four documents, send us at least two documents. A Brella Concierge will be in touch with you if we need more information. Here are examples of the types of supporting documentation you can submit:

- Hospital discharge paperwork
- Summary of care
- Statement of benefits
- Ambulance call report
- Image of hospital wristband
- Image of a prescription for medication
- Image of a prescription medication bottle
- A doctor's bill
- A medical facility bill
- A lab bill
- Lab reports
- Test results
- Imaging results

If you'd like us to work directly with your providers to request additional documentation, please complete the **HIPAA Authorization Form** attached and submit it with your claim and supporting documentation.

Mail your complete claim submission form and supporting documentation to us at:

Fidelity Security Life Insurance Company®
Administered by Brella Services Inc.
Attn: CLAIMS
2093 Philadelphia Pike #2496
Claymont, DE 19703

You can also fax your documents to the Brella Claims Department at 1 (856) 315-6567.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member. You can find an electronic version of this form at <https://joinbrella.com> or you can request additional forms by calling your Brella Concierge at 1 (888) 300-5382.

¿Necesitas ayuda en español? Llama al (888) 300-5382 para recibir ayuda, de lunes a viernes de 8 a.m. a 8 p.m. o los sábados de 9 a.m. a 3 p.m. en horario central.

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Claim Submission Form

Please complete all the fields below and print clearly in blue or black ink.

Claimant information

The claimant is the Brella member for whom this claim is being submitted.

First name _____	Middle name _____
Last name _____	Suffix _____
Relationship to Primary Member (e.g. self, spouse, child) _____	Date of birth _____
Primary member's employer _____	SSN _____
Street address _____	
City _____	State _____ Zip code _____
Phone number _____	May we leave a message at this number? Yes No

Primary Member Information

The primary Brella member is the person who enrolled in Brella at work. You may write 'same as above' if you are a primary member filing a claim for yourself.

First name _____	Last name _____
Date of birth _____	SSN _____
Employer Name _____	

Tell us what happened

Answer each question below and be as specific as possible.

What symptoms did you experience?

What did your provider tell you was wrong?

What treatment did you receive?

Is there anything else we should know?

Tell us where you were treated

Name of treatment facility (you may list multiple):

Type(s) of facility: (circle all that apply) Doctor's Office Urgent Care Hospital Inpatient Emergency Room
Outpatient Surgery Other: _____

Date of Service:

By signing below you attest that you have provided truthful information on this form. 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 confinements in state prison. *****NOTICE – See State-Specific Fraud Notices on Last Page*****

Claimant Signature

(or Authorized Representative)

Claimant Name (please print)

Date

Representative Relationship to Claimant

Fidelity Security Life Insurance Company®
AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION
FOR THE PURPOSE OF INSURANCE CLAIM DETERMINATION

Name of Insured: _____ Date of Birth: _____

Address: _____

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided treatment or services to me or on my behalf within the past 2 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Fidelity Security Life Insurance Company® and to their third-party administrator, Brella Services, Inc. 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 and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information does 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 Fidelity Security Life Insurance Company® may administer claims and determine or fulfill responsibility for coverage and provision of benefits.

This authorization shall remain in force for 30 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 request for revocation to: **Brella Services, Inc.** 2093 Philadelphia Pike #2496 Claymont, DE 19703 Attention: Claims Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that Fidelity Security Life Insurance Company® has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Fidelity Security Life Insurance Company® may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

Signature of Individual Whose Information is to be Disclosed or Authorized Representative

Print Name of Individual or Authorized Representative

Date Signed

COMPLETE AND RETAIN A COPY FOR YOUR RECORDS

Return form by email to support@joinbrella.com or by mail to Brella Services Inc., Attn: Claims, 2093 Philadelphia Pike #2496 Claymont, DE 1970 or by fax to 1 (856) 315-6567.

FRAUD NOTICE: For the states of AL, AZ, AR, CA, CO, DE, DC, FL, GA, IN, KS, KY, LA, MD, ME, NC, NE, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of 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.

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, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of 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: For your protection, California 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: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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.

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.

Georgia, Oregon, Vermont: Any person who with intent to defraud or knowing that 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.

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.

Kansas: Any person who with intent to defraud or knowing that he or 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 as determined by a court of law.

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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, 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.

Nebraska: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false, incomplete or misleading information is guilty of insurance fraud.

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.

North Carolina: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

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.

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.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: Any person who, with the 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 may have violated state law.