

Sales Representative Responsibilities

It is important the Representative clearly explains the coverage benefits at the time of sale. The Representative must fully explain the type of coverage the applicant is purchasing as well as the limitations and exclusions of the policy and any riders.

- Under no circumstances should a Representative advise an applicant or policyowner that a claim or specific benefit will be paid, or speculate about the amount that a policyowner may receive if a claim were to be paid.
- As a Representative of Family Heritage Division, you do not have the authority to settle claims on behalf of Family Heritage Division, nor can you waive or change the terms of any policy, as indicated in your Marketing Agreement.
- If you discuss a claim with a policyowner, you may be legally obligating Family Heritage Division to pay a claim, which under the terms of the policy may not be payable. Be advised that while these situations are rare, you may be responsible for the amount of the claim payment.

Confidential Information

ALL Claims and personal medical information is confidential. It is imperative claim and medical information are not used without the expressed written consent of the claimant, and only during the period of time it is authorized. Claim authorizations must be updated as mandated by each state.

- This information is provided using the Information Release Authorization (IRA) Form signed by the claimant. Under no circumstances can a Representative use information regarding a claim without the prior approval of the Home Office.
- This form must include the approval of the Home Office.
- Approved forms are available on the Family Heritage Division website under the Sales Professionals section.

General Information

- Please advise your policyholders their brochure and other marketing materials are just an overview of their actual policy. For detailed information and complete benefit guidelines, the policyholder and Representative should always review the actual policy contract, including all limitations and exclusions.
- It is strongly recommended the claimant contact the Customer Service or Claims Department directly for assistance in filing a claim.
- Representatives who assist a policyowner with filing claims are expected to review the policy and rider carefully with the claimant before submitting a claim. At no time should the Representative indicate a claim is payable or will be reviewed within a specific time period. It should be clearly explained to the policyowner that missing documents, incomplete documents or the need for further information will cause the claim to be pended until the required information is received.
- If a claimant is unable to complete and sign a claim form or required HIPAA authorization for, the following may be required: claimant's death certificate, Power of Attorney, Letter of Executor, or other legal documentation.
- Benefits will be severely limited to policyholders who are Medicaid or state-assisted government program recipients at the time of a claim. As required by law, benefits will be paid to Medicaid, the state-assisted programs or the provider of service instead of directly to the insured. These claim payments will affect any Return of Benefit/ Cash Value amounts.
- ICU claims are paid only if the patient was billed for the highest level of the Intensive Care or Coronary Care Unit. **The billing rates charged by the hospital will be used to determine when the highest level of medical care is delivered.**

Filing a Claim

- Claims may be submitted by mail, fax, or electronically through our eClaims website portal.
- eClaims site includes detailed instructions, helpful checklists, FAQ, and claim forms.
- For faster filing, it is recommended to submit claims electronically where supporting documents can be easily uploaded.

*Please note that due to confidentiality and privacy regulations, claims are not accepted via email.

Claim Review Process

Review

- While a claim is under review, Examiners are not permitted to discuss the claim status with the Representative or the policyowner until the process is completed and the decision has been approved.
- It is the responsibility of the Claims Department to make decisions on claims. The Claims Department will review documentation such as medical records, claim forms, and bills, etc., as well as the policy language, applications, and exclusion riders to make a determination on a claim.
- Representatives are not authorized to make decisions on claims. Therefore, they should never commit the Claims Department to a certain turnaround time or imply to a policyowner that a claim is payable.
- All of our policyowners are important to us. Therefore, the Examiners do not make any exceptions or process certain claims ahead of others based on policyowner or Representative requests.
- The turnaround time for a claim to be reviewed (pending, denied, paid, or closed), is determined by the need for additional information, such as medical records and other documents, as well as the current volume of claims in the Claims Department.

Pended Claims

- A claim will be "pending" if there is a need to request additional information. This may include medical records, itemized bills, missing or incomplete claim forms, pathology reports, police reports, or other necessary documents.
- A letter will be sent to the policyowner to notify them additional information must be received in order to review the claim further.
- Under no circumstances should the Representative become involved in the process of obtaining medical records, or contact a physician's office or other medical facility on behalf of a claimant in an attempt to obtain information faster.

Closed Claims

- A claim may be closed if there have been unsuccessful attempts to obtain required information, or other various reasons based on the information the Claims Department received.
- A letter will be sent to the policyowner to notify them that additional information must be received in order to reopen the claim.

Denied Claims

- After review of all information, the Claims Department may determine that a claim must be denied.
- The policyowner is sent a letter explaining why the claim is not payable.
- If the policyowner wishes to appeal the decision, they must do so in writing. Upon receipt of the written request, the claim will be reopened and reviewed. The policyowner will be notified in writing of the decision.



Payable Claims

- After review of all information, the Examiner may determine that a claim is payable.
- The claim is then processed and verified for accuracy.
- The Representative should never tell a policyowner that they should expect to receive a claim payment within a certain time frame.
- The policyowner will be paid through ACH or manual check and will receive a statement explaining the benefits that were paid.

Medical Records

- Medical Records must be sent directly from the physician or medical facility to the Claims Department. Records submitted by the policyholder or Representative will not be accepted.
- It is important to know that it may take some time for the provider to submit medical records and other necessary documents to us.

Rescissions

- If after reviewing the information it is found a claim will not be paid due to misrepresentation or ineligibility for coverage, then the policy may be rescinded.
- Family Heritage Division will provide a letter to the policyowner or beneficiary explaining the reason for the rescission.
- All premiums paid on the policy (plus interest, if required by law) will be returned.

