HERE'S WHAT YOU SHOULD KNOW IF YOUR HUSBAND IS INJURED WHILE ON DUTY :

WORKMAN'S COMP:

This covers your husband's paycheck and necessary medical needs.

RISK MANAGEMENT:

Call Mary Lou Crocker at 702-828-3696 if you have any questions or concerns. She is the "Health Liaison" between Health & Safety/Workman's Comp and she will be able to direct you in the right direction.

HEALTH INSURANCE:

Your employer's insurance covers medically necessary drugs and equipment your doctor prescribes. Make sure you get prescriptions approved and filled prior to surgery, if possible, so you are not waiting for meds post-surgery.

PEAP (POLICE EMPLOYEE ASSISTANCE PROGRAM):

These are counsellors who ensure you have all emotional, psychological, and in-home resources that are available to you and your family during your time or need. This group of people will make themselves available to you for ALL emotional needs, whether your husband is going through an OIS (officer involved shooting), has had a traumatic experience at work, has been injured at work, or even if you just have issues you'd like to discuss. If you, your husband or your children need to talk to a counselor or therapist to helpprocess any events that have happened,they'll see to it that you all get the proper professional help. Volunteer chaplains work in conjunction with the LVMPD Police Employee Assistance Program. They familiarize themselves with the Department's personnel and will provide a supportive presence to officers, their families, as well as the community, and provide spiritual counsel when appropriate. PEAP's Main Line is 702-828-3357

IPOF (INJURED POLICE OFFICER'S FUND):

They are a nonprofit that operates outside of the department with members of all law enforcement agencies in the area sittingon their board representing your best interests. Their mission is to reduce the financial burden of the families. The IPOF will provide a $500 emergency disbursement (board approval) on the day of injury should an officer be admitted to help with the family's IMMEDIATE needs, which differ from family to family. They then will cover anything Workman's Comp doesn't cover. YOU must have a workman's comp "acceptance letter" and then contact them to fill out their forms to receive any resources available to you and your family.
Examples: Childcare expenses, meals, spouse's salary if they miss work due to caring for you, necessary landscape maintenance, etc. There are many more things that The IPOF will cover, just call and ask! IPOF is there to raise money to help you in circumstances when your husband Is injured on the job, so utilize that tremendous resource!! Remember supporting documents are required so be sure to keep receipts. IPOF 702-380-2840

AFLAC:

Remember this is something all of our husbands were asked to sign up for during their time at the academy. You can file all claims that are applicable to the coverage you have for your family through them directly. AFLAC 702-871-9997

LVMPO WIVES:

We are here for support of all kinds emotional, physical & moral, babysitting, mealtrains, running errands! Everyone is willing to help with anything you may need so please just speak up and let us know your situation.

website: www.lvmpowives.com
emaiL: lvmetropolicewives@gmail.com

"Together we are Stronger!
After all, we're all in this together!"

APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

Name (Last, First, Middle Initial)			Claim Number
Present Address (P.O. Box, Apt. No., Street)			Social Security Number
City	State	Zip	Date of Injury
Residence at time of injury:			(For Insurer's Use Only) [__] Approved ______________ [__] Disapproved Initials & Date

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

Date	Beginning Point of Travel Address	Destination Name/Address	Enter Travel Time	Leave Travel Time	Daily Expense Reimbursement				Miles One Way	Mileage Allowed (For Insurers Use Only)
					Meals			Lodging		
					B	L	D			
								TOTAL MILES:		
Total of _____________ Miles X 2 @ $ ________ . ____ per Mile =										

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

____ _____________________________

Injured Employee's Signature Date

Reimbursement for Costs of Transportation and Meals

Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives medical care; or

(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

NAC 616C.153 Reimbursement for air fare. With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

NAC 616C.156 Limitations on reimbursements.

1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

Notice

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than $250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to $1,000. If the amount of the benefit or payment is $250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to $5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

Accident/Hospital Indemnity Wellness Benefit Claim Form

If you are interested in filing your claim online, register using aflac.com/smartclaim.

- **Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.**

Please read all instructions.

Failure to follow these instructions could delay the processing of your claim.

Your Aflac policy provides a Wellness Benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please check your policy for specific details on this benefit.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Please sign, date and mail or fax the completed form to the Aflac address/fax number shown below.
- Please use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam box(es) for test(s) that you had performed.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

Accident/Hospital Indemnity Wellness Benefit Claim Form

Policy Number:

All Fields are required.

Policyholder Information:

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) / /

Telephone Number where we can reach you - -

Home Address

City | State | Zip Code

☐ *Check box if this is permanent address change.*

Patient Information:

Last Name | First Name | Date of Birth (mm/dd/yy) / /

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treatment and Physician Information

Treatment Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Pap Smear Date: M M D D Y Y Y Y

☐ Annual Physical

☐ Ultrasound

☐ PSA (blood test for prostate cancer)

☐ Pap Smear

☐ Blood Screening

☐ Immunizations

☐ Eye Exam

☐ Mammogram

☐ Dental Exam

☐ Flexible Sigmoidoscopy

Physician's Phone Number: - -

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

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.

The Provider listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

ACCIDENTAL INJURY CLAIM FORM

Thank you for trusting Aflac with your Accidental Injury needs.

- **If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

*Policy Number:

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) / / | Telephone Number where we can reach you - -

*Home Address

*City | *State | *Zip Code -

☐ *Check box if this is a permanent address change.*

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy) / /

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Accidental Injury Checklist

- Date of the injury: ______/______/______
- Describe how the injury occurred: ______
- Was this injury caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Was injury a result of participating in an organized sporting activity? ☐ No ☐ Yes
  Type of Event______ Sporting Organization______
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.)
- Was death a result of this injury? ☐ No ☐ Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)
- Was the patient confined to the hospital as a result of this injury? ☐ No ☐ Yes (If yes, please submit the UB04 (Universal Billing 2004), itemized hospital bill, or HCFA 1500.)
- Hospital Name: ______
- City ______ State ______

If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

*Policy Number:

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) / /

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy) / /

- Was the patient transported by an ambulance as a result of this injury? ☐ No ☐ Yes (If yes, please submit the ambulance bill.)
- Was an aid in locomotion (mobility) prescribed as a result of this injury? (I.e. crutches, wheelchairs, leg braces, back braces, walkers, cervical collars, etc.) ☐ No ☐ Yes (If yes, please submit documentation from the prescribing provider, UB04 or HCFA 1500.)
- If any of the following were the result of your injury, please provide medical records, physician's office notes, or any bills received for these conditions that describe the diagnosis or type of treatment received:
  - Coma
  - Paralysis
  - Burn
  - Injury to the Eye
  - Laceration
  - Dislocation
  - Concussion (major diagnostic exam reports are acceptable)
  - Fractures (x-ray reports or major diagnostic exam reports are acceptable)
- Was surgery performed as a result of this injury? ☐ No ☐ Yes (If yes, please submit a copy of the operative report or detailed billing from the surgeon's office, such as UB04 or HCFA 1500.)
- Was a major diagnostic exam (i.e. CT Scan, MRI, MRA, EEG) performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report, billing information, UB04 or HCFA 1500.)
- Dates of treatment related to injury (please submit supporting medical documentation for each visit indicated below):

Date	Provider Name	Provider Address	Provider Phone Number	Type of Treatment
				☐ Follow up ☐ Therapy *
				☐ Follow up ☐ Therapy *

* Some policies provide benefits for therapy including physical, speech, and occupational therapy. Not all types are available on all policies. Please submit information indicating date of treatment, treatment type, and who provided it to determine benefit.

- Transportation/Lodging Information: Please complete if you are filing a claim for transportation or lodging and please submit the hotel receipts and mileage information. For additional information, please refer to your policy language.

Date	To/From	Round-Trip Mileage

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.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

HOSPITAL INDEMNITY CLAIM FORM

Thank you for trusting Aflac with your Hospital Indemnity needs.

➢ **If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

➢ **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
➢ **Failure to complete all sections may result in a delay in processing this claim.**
➢ **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:** ☐☐☐☐☐☐☐☐

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) __ __ / __ __ / __ __ | Telephone Number where we can reach you ___ - ___ - ____

*Home Address

*City | *State | *Zip Code _____ - ____

☐ *Check box if this is a permanent address change.*

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy) __ __ / __ __ / __ __

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Hospital Indemnity Checklist

***If filing for a claim within the first two years of the policy, medical records may be requested for evidence of insurability.**

Is treatment due to an injury? ☐ No ☐ Yes ***If yes, please complete the following questions related to the injury:***

- Date of the injury: ______/______/______
- Describe how the injury occurred: ________________________________
- Was this disability caused by an incident that occurred while performing the duties of the patient's employment? ☐ No ☐ Yes
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.)

Is treatment due to a sickness? ☐ No ☐ Yes ***If yes, please complete the following questions related to the sickness:***

- Symptoms first occurred on: ______/______/______
- First date of treatment for this condition: ______/______/______
- If diagnosed with cancer, date of initial diagnosis: ______/______/______
- Was the patient treated by any other physicians for this sickness or a related condition? ☐ No ☐ Yes

  If yes, physician's name(s): ________________________________

  Phone Number(s): ________________________________

  Address: ________________________________

If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

*Policy Number:

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) / /

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy) / /

Pregnancy claims:

- Date of delivery: ____/____/____ ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: ____/____/____
- Please advise of any complications: ____________________

For all claims, please complete all remaining sections.

- Please provide the name, address and phone number of the patient's primary treating physician.
  Name: ____________________ Phone Number: ____________________
  Address: ____________________
- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Hospital Name: ____________________
  City: ____________________ State: ____________________
- Was the patient confined to the intensive care unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was the patient confined to a rehabilitation unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was patient treated in an emergency room as a result of this condition? ☐ No ☐ Yes (If yes, please submit the emergency room report, UB04, or HCFA 1500.)
  Hospital name: ____________________ Date of treatment: ____/____/____
- Was the patient transported by an ambulance as a result of this condition? ☐ No ☐ Yes (If yes, please submit the ambulance bill)
- Was surgery performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the operative report, UB04, or HCFA 1500.)
- Were medical imaging services (i.e. CT Scan, MRI, EEG, etc.) provided as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report and/or billing, UB04, or HCFA 1500.)

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.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**