

Fax to: Claims 1.866.611.9954

From: \_\_\_\_\_

No# of pages: \_\_\_\_\_

Or Mail to: P.O. Box 100266

Columbia SC 29202-3266

# Critical Illness



**Fax this direction.**

**Please be sure to send the following information:**

- ✓ Medical Documentation for your condition,
- ✓ Diagnosis (ICD9) codes,
- ✓ Signed and dated authorization

**OPTIONAL SERVICE RELEASE AGREEMENT** – Please initial below for optional services. Any other marks used (check mark, x, etc.) will not be considered as authorization and will be processed as blank.

**I authorize Colonial Life to facilitate processing this claim by releasing its details to the individual inquiring on my behalf. Leave blank if you do not want anyone accessing your claim information.**

\_\_\_\_\_ sales representative \_\_\_\_\_ plan administrator

\_\_\_\_\_ spouse, family member or significant other

\_\_\_\_\_ I want Colonial Life to update me on the status of my claim through electronic messaging at my home phone number indicated on this form. Messages will be left with anyone that answers the phone or on my answering machine. To avoid blocked calls, I should program the number 1.800.325.4368 into my phone.

\_\_\_\_\_ Yes, I want **ALL** payment(s) for this claim sent by overnight delivery. I understand payment(s) under \$100.00 cannot be sent overnight and an \$18.00 fee, which is subject to rate increases by carrier and **does not include weekend delivery**, will be deducted from my claim payment(s). **We are unable to overnight mail to a P.O. Box and you must notify us in writing to discontinue this service.**

*If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)*

Section 1 TO BE COMPLETED BY POLICY OWNER		
Claimant name <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Claimant Social Security Number
Relationship to Policy Owner: <input type="checkbox"/> spouse <input type="checkbox"/> dependent <input type="checkbox"/> self <input type="checkbox"/> domestic partner		
Policy owner (First, Last)	Birth Date	Social Security Number
Mailing Address (Street or PO Box)		(Apartment/Unit/Lot Number)
(City)	(State)	(Zip) Daytime Phone
Policy owner e-mail address		
What type of illness are you claiming?	When were you first treated for this illness? _____ (MM/DD/YYYY)	
Do you have a disability policy with us? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, dates you are unable to work. From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)	Employer's Name _____ Telephone _____ Fax _____	

## Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others require the following statement to appear on this claim form.

**Fraud Warning :** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

**Arizona Residents :** 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.

**California, Rhode Island, Texas and West Virginia Residents :** For your protection, California, Rhode Island, Texas and West Virginia 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 Residents :** 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.

**District of Columbia and Maryland Residents :** 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 Residents :** 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.

**Kentucky :** For your protection, Kentucky law requires the following to appear on this form: 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.

**Maine, Tennessee, Virginia and Washington Residents :** 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.

**New Jersey and New Mexico :** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York Residents :** 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.

**Pennsylvania Residents :** 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.

**Oregon Residents :** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**Puerto Rico Residents :** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**CERTIFICATION**

**Policy owner's Name** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page 2 of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. **Fraud Warning: 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.**

**Please remember to also sign and date the attached authorization required to process your claim.**

X \_\_\_\_\_  
Claimant's Signature

X \_\_\_\_\_  
Policy owner's Signature

X \_\_\_\_\_  
Date (MM/DD/YYYY)



**Fax this direction.**

<u>Treating Doctor's Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Primary Doctor's Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Referring Doctor or Hospital Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Referring Doctor or Hospital Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Referring Doctor or Hospital Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		

<b>Section 2 TO BE COMPLETED BY PHYSICIAN</b>	
<b>Patient's Name</b>	<b>Patient's Date of Birth</b>
<b>For each condition listed in the chart below for which you are treating this patient, please enclose the information listed under the Medical Documentation Needed section.</b>	
<b>Blindness if applicable to your policy</b>	<b>Medical documentation of clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or visual field restriction to 20 degrees or less in both eyes.</b>
<b>Bypass Surgery as a result of Coronary Artery Disease</b>	<b>Surgical report that documents procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts.</b>
<b>Cancer and/or Carcinoma in situ</b>	<b>A pathology report confirming the pathological diagnosis of cancer or carcinoma in situ by a certified pathologist. If a pathological diagnosis cannot be made provide medical evidence to support a clinical diagnosis of cancer or carcinoma in situ based on the study of symptoms.</b>
<b>End Stage Renal Failure</b>	<b>Medical documentation of regular hemodialysis or peritoneal dialysis.</b>
<b>Heart Attack (Myocardial Infarction)</b>	<b>Diagnosis supported by three or more of the following indicators: medical records documenting typical chest pain suggestive of heart attack; new EKG report showing changes indicative of myocardial infarction; medical reports documenting increase of specific cardiac markers typical for heart attack, or medical reports of confirmatory imaging studies. (In the event of death, an autopsy confirmation identifying heart attack as the cause of death will be accepted.)</b>
<b>Permanent Paralysis (due to Covered Accident) if applicable to your policy</b>	<b>Medical documentation of complete and permanent loss of the use of two or more limbs for a continuous period of 180 days.</b>
<b>Stroke</b>	<b>Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event and confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.</b>
<b>Transplant as the result of Heart Failure</b>	<b>Surgical report that documents transplant of a human heart</b>
<b>Transplant as a result of a Major Organ Failure (human lung, liver, kidney or pancreas)</b>	<b>Surgical report that documents transplant of the human organ.</b>
<b>Provide the diagnosis(es), the date of diagnosis, and the ICD-9 code(s) for the conditions for which you are treating this patient.</b>	

Diagnosis	Date of Diagnosis	ICD-9 Code
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	

Has this patient been treated for this same or similar condition in the past prior to this occurrence? \_\_\_ Yes  
\_\_\_ No

Diagnosis	First Date of Treatment	Referring Doctor's Name and Telephone
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	

**FRAUD NOTICE:** Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

<p>_____ Medical Provider's Name(Please Print)</p> <p>_____ Medical Provider's Signature</p>	<p>( ) _____ ( ) _____ Phone Number      Fax Number</p> <p>_____ Date (MM/DD/YYYY)</p>
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**Fax this direction.**

**Authorization for Colonial Life & Accident Insurance Company**

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments. Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

X \_\_\_\_\_ XXX-XX-\_\_\_\_\_  
(Signature) (Social Security Number — last 4 digits) (Date of Birth)

\_\_\_\_\_  
(Printed name of individual subject to this disclosure) (Date Signed)

If applicable, I signed on behalf of the insured as \_\_\_\_\_(indicate relationship).  
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

\_\_\_\_\_  
(Printed name of legal representative) (Signature of legal representative) (Date Signed)  
Authorization