



UNUM<sup>®</sup>

### CRITICAL ILLNESS CLAIM FORM

Mail to: UnumProvident  
P.O. Box 12030, Chattanooga, TN 37401  
Toll Free: 877-873-5809 Fax: 423-755-3009

**SECTION A**

<b>Policyholder Information</b>				<b>Patient Information</b> Check One <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self			
Policy Number(s)							
Name (First, Middle, Last)			<input type="checkbox"/> Male <input type="checkbox"/> Female	Name (First, Middle, Last)			<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street)		<input type="checkbox"/> Check here if NEW address		Apt #		Address (Street)	
<input type="checkbox"/> Check here if NEW address		Apt #		Address (Street)		<input type="checkbox"/> Check here if NEW address	
City		State		Zip Code		City	
State		Zip Code		City		State	
Zip Code		City		State		Zip Code	
Social Security Number		Date of Birth		Social Security Number		Date of Birth	
_____ / _____ / _____		_____ / _____ / _____		_____ / _____ / _____		_____ / _____ / _____	
Home Phone Number ( ) ( )		Work Phone Number ext. ( ) ( )		Home Phone Number ( ) ( )		Work Phone Number ext. ( ) ( )	

**SECTION B**

What type of illness are you claiming?				When were you first treated for this illness? (Date mm/dd/yyyy) ____ / ____ / _____			
<b>Primary Doctor</b> Name				<b>Treating Doctor</b> Name			
Address (Street)				Address (Street)			
City		State		Zip Code		City	
State		Zip Code		City		State	
Zip Code		City		State		Zip Code	
Phone Number ( ) ( )		Fax Number ( ) ( )		Phone Number ( ) ( )		Fax Number ( ) ( )	

**HOSPITAL INFORMATION (If ever hospitalized or seen at the hospital for this condition)**

Hospital Name				Hospital Name			
Address				Address			
City		State		Zip Code		City	
State		Zip Code		City		State	
Zip Code		City		State		Zip Code	
Date Seen/Admitted		_____ / _____ / _____		Date Seen/Admitted		_____ / _____ / _____	
_____ / _____ / _____		_____ / _____ / _____		Date Discharged		_____ / _____ / _____	
Date Discharged		_____ / _____ / _____		_____ / _____ / _____		_____ / _____ / _____	

**SECTION C**

**AUTHORIZATION** POLICYHOLDER'S NAME (Print) \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility, insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation, other organization, institution, or person that has any records or knowledge of me, my health (including any disorder of the immune system including HIV or AIDS, any information relating to the use of drugs and alcohol, and any information relating to mental and physical history, condition, advice or treatment), financial or credit information, earnings, employment history or other insurance benefits, to release this information to any of the UnumProvident Corporation subsidiaries or their duly authorized representatives. I also authorize the UnumProvident Corporation subsidiaries to request a report from the Medical Information Bureau (MIB), and the association of life insurance companies which operates the Health Claims Index (HCI) and the Disability Income Record System (DIRS). I understand that the dates of my past and present claims with any of the UnumProvident Corporation subsidiaries, excluding medical or personal information, may be reported to MIB and that an HCI or DIRS report may reflect this information including the identity of other insurance companies to which I have submitted claims. I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering a claim for benefits.

This authorization is valid for the duration of my claim. I know that I or my authorized representative has a right to request a copy of this authorization. A copy of this authorization shall be as valid as the original.

I further authorize the UnumProvident Corporation subsidiaries or other authorized representatives to release all information (including information pertaining to HIV or AIDS, mental illness, and drug and alcohol abuse) related to this insurance claim to insurance companies, third party administrators, physicians, rehabilitation professionals, vocational evaluators, employers, my insurance agent, and any institution or person on a need to know basis for the purpose of verifying, evaluating, negotiating, or other pertinent uses with respect to my claim for benefits or service.

The statements made by me on this claim are true and complete.

I further authorize the UnumProvident Corporation subsidiaries or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

I am the individual to whom this release/request applies or that person's legal Guardian, Power of Attorney, or Conservator. I know that if I make any representation which I know is false to obtain information from federal records, I could be punished by fine or imprisonment or both.

Signature of Claimant **X** \_\_\_\_\_ Please Print Name \_\_\_\_\_

Date Signed \_\_\_\_\_ Social Security Number \_\_\_\_\_

I signed on behalf of the claimant, as \_\_\_\_\_ (indicate relationship). **If Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.**

## **CLAIM FRAUD WARNING STATEMENTS**

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

### **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.

### **Fraud Warning for California Residents**

For your protection, California law requires the following to appear:

Any person who knowingly, presents a 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.

### **Fraud Warning for 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.

### **Fraud Warning for District of Columbia, Maine and Virginia Residents**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

### **Fraud Warning for Florida Residents**

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

### **Fraud Statement for New Jersey, New Mexico and 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.

### **Fraud Statement for New York Residents**

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing 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.

# ATTENDING PHYSICIAN'S STATEMENT - CRITICAL ILLNESS

## PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION

1. Patient's Name (First, middle initial, last name)	2. Patient's Birthdate ____ / ____ / ____	3. Patient's Address (street, city, state, zip code)
4. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
6. Patient's or Authorized Person's Signature (I authorize the release of any medical information necessary to process this claim).		

Signed \_\_\_\_\_ Date \_\_\_\_\_

## PHYSICIAN OR SUPPLIER STATEMENT

7. Date of Illness (first symptom) OR Injury (accident)	8. Date first consulted you for this condition	9. Has patient previously had same or similar condition: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, show first treatment date(s)	<b>10. PLEASE CHECK TESTS CONDUCTED FOR THE PATIENT HEALTH TESTING</b> <input type="checkbox"/> Blood Test for Triglycerides <input type="checkbox"/> Bone Marrow Aspiration/Biopsy <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> CA 15-3 (Blood Test for Breast Cancer) <input type="checkbox"/> CA 125 (Blood Test for Ovarian Cancer) <input type="checkbox"/> CEA (Blood Test for Colon Cancer) <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Fasting Blood Glucose Test <input type="checkbox"/> Flexible Sigmoidoscopy <input type="checkbox"/> Hemocult Stool Analysis <input type="checkbox"/> Mammography <input type="checkbox"/> Pap Smear <input type="checkbox"/> PSA (Blood Test for Prostate Cancer) <input type="checkbox"/> Serum Cholesterol Test to Determine Level of HDL and LDL <input type="checkbox"/> Serum Protein Test to Determine Level of HDL and LDL <input type="checkbox"/> Skin Cancer Biopsy <input type="checkbox"/> Stress Test on Bicycle or Treadmill <input type="checkbox"/> Thermography <input type="checkbox"/> Thin Prep Pap Test <input type="checkbox"/> Other _____
11. Name of referring or other treating physicians		12. For services related to hospitalization give hospitalization dates Admit: _____ Disch: _____	
13. Name and address of facility where services rendered (if other than home or office)			
14. Diagnosis or nature of illness or injury, relate diagnosis to procedure by reference in Column D to Numbers 1, 2, 3, etc. or DX code. Note: if possible please give CPT-4 procedure code in the "C" below and ICD-9 in "D".			

- 1.
- 2.
- 3.
- 4.

15. A Date of Service	B* Place of Service	C	Fully describe procedures, medical services or supplies furnished for each date given (Explain unusual services or circumstances)	D Diagnosis Code	E Charges
		Procedure Code (Identify: )			

16. Total Charge

17. Medical Providers Signature and Medical Specialty	18. Your Social Security Number or Taxpayer I.D. Number (required by law)
Signed _____ Medical Specialty _____ Date _____	
19. Your Patient's Account Number	

20. Please provide the test results, operative reports, pathology reports, and/or your detailed medical statement for the claimed condition below:

<b>Condition</b>	<b>Medical Documentation</b>
Cancer	Pathology Report
Carcinoma in situ	Pathology Report and/or Clinical Diagnosis
Coronary Artery Bypass Surgery	Open heart surgical report
End Stage Renal Failure	Regular hemodialysis and/or Peritoneal dialysis
Heart Attack	Any of the following: Electrocardiograph (EKG), Cardiac enzymes, Thallium scans, MUGA scans, Stress echocardiogram
Major Organ Transplant	Surgical Reports
Stroke	Documented neurological deficits and/or Neuroimaging studies
Permanent Paralysis	Clinical Diagnosis

- \*Place of Service Codes
- |                               |                             |  |   |
|-------------------------------|-----------------------------|--|---|
| 11–Office                     | 26–Military Facility        | 51–Inpatient Psychiatric Facility                  | 62–Comprehensive Outpatient Rehabilitation Facility |
| 12–Home                       | 31–Skilled Nursing Facility | 52–Psychiatric Facility Partial Hospitalization    | 65–End Stage Renal Disease Treatment Facility       |
| 21–Inpatient Hospital         | 32–Nursing Facility         | 53–Community mental Health Center                  | 71–State or Local Public Health Clinic              |
| 22–Outpatient Hospital        | 33–Custodial Care Facility  | 54–Intermediate Care Facility/Mentally Retarded    | 72–Rural Health Clinic                              |
| 23–Emergency Room/Hospital    | 34–Hospice                  | 55–Residential Substance Abuse Treatment Facility  | 81–Independent Laboratory                           |
| 24–Ambulatory Surgical Center | 41–Ambulance (Land)         | 56–Psychiatric Residential Treatment Center        | 99–Other Unlisted Facility                          |
| 25–Birthing Center            | 42–Ambulance (Air or Water) | 61–Comprehensive Inpatient Rehabilitation Facility |   |
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