HELPFUL HINTS

CRITICAL ILLNESS CLAIM FORM

We value you as a Policyholder and want to make the process of filing a claim as fast and as simple as possible. Please refer to your policy language as benefits vary depending upon coverage selected. To assist you with the process, we are providing these helpful hints:

SUBMITTING A CLAIM

When submitting a claim, attention to the following details will assure that the claim will be processed in a timely manner:

■ Submit a fully completed and signed claim form.

■ Complete and sign the "Authorization to Obtain Medical/Confidential Information" form provided with the claim form.

■ Be sure to include the provider's name, address and phone number with all claims.

■ Have your physician complete the part(s) of the claim form that corresponds to the specific plan under which you are filing for benefits:

- Part 3 – Cancer
- Part 4 – Heart Attack, Stroke, Coronary Artery Bypass Graft and Angioplasty
- Part 5 – End Stage Renal Failure

■ Provide the first diagnosis date for the health condition for which bills are being submitted.

■ Provider bills should include dates of service, procedure and diagnosis description or codes.

■ For cancer related benefits, a positive pathology report or clinical diagnosis documentation must be submitted.

Before mailing, be sure to include:

1. **Your itemized bills containing your procedure and diagnosis codes.**
2. **Your pathology report, if applicable or documentation of clinical diagnosis, if applicable.**
3. **Your completed claim form.**

HOW TO SUBMIT CLAIMS

Mail all Critical Illness claims to:

Claim Department
PO Box 2024
Carmel IN 46082-2024
(800) 621-3724

Express packages should be addressed to:

Attn: Claim Department - 2024

11825 N. Pennsylvania Street

Carmel, IN 46032

(800) 621-3724

Fax all Critical Illness claims to:

(317) 208-8656

Please note: Explanation of Benefits (EOBs) from another insurance company cannot be used to consider benefits. Provider bills must be submitted.

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Bankers Life and Casualty Company
PO BOX 2024
Carmel IN 46082-2024
1-800-621-3724

CRITICAL ILLNESS CLAIM FORM

Part 1 – POLICYHOLDER INFORMATION

Policyholder: _____ Policy Number: _____

Address: _____ Date of Birth: _____

_____ Social Security #: _____

Phone Number: _____ Check here if new address ☐

Part 2 – STATEMENT OF LOSS (to be completed by Policyholder)

Describe condition/sickness: _____

_____

Date of first treatment for this condition/sickness: _____

Was this loss a result of an accident? _____Yes _____No Date of Accident: _____

If yes, please describe accident: _____

If hospitalized, when? _____

Hospital Name, Address and Phone Number: _____

_____

Is the Insured deceased? _____Yes _____ No Did this loss result in the death of the Insured? _____ Yes _____No

Please submit a certified copy of the Insured's death certificate, if applicable.

List all Physicians who have treated you for the condition, include Name, Address and Phone Number:

Name	Address	Phone Number

Signed (Policyholder/Attorney in Fact under Power of Attorney document) Please submit the Power of Attorney legal documentation

DATE

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PART 3: PHYSICIAN'S STATEMENT FOR CANCER CLAIM
(To be completed by Physician's Office)

Patient's Name: _____ **Date of Birth:** _____

Physician's Name (Specialty): _____

_____

Address: _____
(Street)

_____
(City) (State) (Zip Code)

Phone Number: _____

SECTION A: Cancer Claim

Describe Condition: _____

_____

When was any type of cancer first diagnosed? _____ Type? _____

Is this Patient's past medical history on file in your office? _____

Please indicate the name and address of the referring Physician: _____

_____

Please attach documentation that supports diagnosis such as a copy of itemized bill(s) and laboratory report that includes:

- **date(s) of service**
- **diagnosis code(s)**
- **procedure code(s)**

Please attach copies of the pathology reports for all cancer surgeries, if applicable.

Physician's Signature: _____

Date: _____

Tax ID Number: _____

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PART 4: PHYSICIAN'S STATEMENT FOR HEART ATTACK, STROKE, CORONARY ARTERY BYPASS GRAFT AND/OR ANGIOPLASTY: (To be completed by Physician's Office)

Patient's Name: _____ **Date of Birth:** _____ ____

Physician's Name (Specialty): _____ _____

_____

Address: _____
(Street)

_____ _
(City) (State) (Zip Code)

Phone Number: _____

To your knowledge has the patient ever been diagnosed or treated for the following conditions:

Condition	**Yes**	**No**	**Date**	**Condition**	**Yes**	**No**	**Date**
Heart Attack				Arteriosclerosis			
Heart Disease				High Blood Pressure			
Heart Abnormality				Stroke			
Disorder of Coronary Arteries				If Stroke, did stroke result in paralysis lasting more than 24 hours?			
Heart Transplant				Transient Ischemic Attack			
Coronary Artery Bypass Graft				Angioplasty			
Any other Heart Condition:							

Is this Patient's past medical history on file in your office? _____

Please indicate the name and address of the referring Physician:_____

_____

Please attach documentation that supports diagnosis such as a copy of itemized bill(s) and laboratory report that includes:

- **date(s) of service**
- **diagnosis code(s)**
- **procedure code(s)**

Please include copies of EKG, lab studies and/or scan reports that confirm the Heart Attack, Stroke, Coronary Artery Bypass Graft and/or Angioplasty diagnosis.

Physician's Signature: _____ Date: _____

Tax ID Number: _____

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PART 5: PHYSICIAN'S STATEMENT FOR END STAGE RENAL FAILURE
(To be completed by Physician's Office)

Patient's Name: _____ Date of Birth: _____

Physician's Name (Specialty) _____ Phone Number: _____

Address _____
(Street)

_____
(City) (State) (Zip Code)

To your knowledge has the Patient ever been diagnosed or treated for:

Condition	**Yes**	**No**	**Date**
End Stage Renal Failure			

Has the Patient been recommended for dialysis or kidney transplant? _____ Yes _____ No

Is this Patient's past medical history on file in your office? _____

Please indicate the name and address of the referring Physician: _____

_____

Please attach documentation that supports diagnosis such as a copy of itemized bill(s) and laboratory report that includes:

- **date(s) of service**
- **diagnosis code(s)**
- **procedure code(s)**

Physician's Signature:_____ ____ Date:_____

Tax ID Number: _____

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FRAUD WARNING NOTICES
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

ALASKA, DELAWARE, FLORIDA, IDAHO, NEW YORK: Your state requires us to notify you that: any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony as further defined by your state statute.

ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, WEST VIRGINIA: 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 fines and confinement in prison.

ARIZONA, KENTUCKY, OHIO: WARNING: any person who, with 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 is guilty of insurance fraud.

CALIFORNIA: For your protection California law requires the following warning statement to appear on this form: 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.

COLORADO: WARNING: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

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.

INDIANA, MINNESOTA: Your state requires us to notify you that: any 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.

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.

NEW HAMPSHIRE: Your state requires us to notify you that any person, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud under New Hampshire law.

NEW JERSEY, PENNSYLVANIA: NOTICE: 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.

OKLAHOMA: WARNING: any person who knowingly, and with intent to injure, defraud or decieve any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PUERTO RICO: 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 dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] 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.

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 include imprisonment, fines and denial of insurance benefits.

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Authorization to Obtain Medical/Confidential Information

Conforms to HIPAA Privacy Rule

1. My Information – the individual who is the subject of the information

Printed Name	Date of Birth	Social Security Number

Address	City	State	Zip

2. Disclosing Party – parties authorized to release information about me

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency or my employer

3. Description of my information authorized for release

- Any information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse; and
- Any information regarding my past, present or future employment that is reasonably necessary to process and administer my claim(s) for accident insurance and/or disability income insurance benefits.

4. Purpose of Authorization – how my information will be used

To administer benefits under a policy or certificate of insurance.

5. Duration of Authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: _____

6. Receiving Parties – parties authorized to receive information about me

CNO Services, LLC on behalf of one or more of the following insurance companies: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company*, Colonial Penn Life Insurance Company, Conseco Life Insurance Company, Conseco Life Insurance Company of Texas, Washington National Insurance Company, Primerica Life Insurance Company, Jefferson National Life Insurance Company **domiciled in and licensed in the State of New York*

7. Important information – review carefully before signing

- Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
- This Authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: Customer Service P.O. Box 2024, Carmel, IN 46082-2024.
- The Receiving Parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I have a right to a copy of this Authorization, and that a photocopy or facsimile is as valid as the original.
- California residents are entitled to a large print version of this form by calling 800-541-2254 to request form HEALTHMEDAUTH-LARGE.

8. Approval – must be signed and dated by me or my Legal Representative* to be valid

Printed Name	Relationship to the Insured
Signature	Date Signed

**Legal Representatives must provide documentation of legal authority*

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