Bankers Life and Casualty Company
Home Office: 11825 N. Pennsylvania St., Carmel, IN 46032

Questions about your claim submission?
CALL (800) 621-3724

Living Benefit Chronic Illness Accelerated Death Benefit Claim Form

Please submit these items with all claims:

- Living Benefit Chronic Illness Accelerated Death Benefit Claim Form – All sections completed
  - The patient or responsible person must complete Sections A, B and C and sign.
  - The Licensed Healthcare Practitioner must complete Section D and sign.
- Authorization to obtain medical/confidential information (see attached form)—Completed and signed

Where to Submit Claims:

- ***Mail:*** Bankers Life and Casualty Company, P.O. Box 1936, Carmel, IN 46082-1936
- ***Express mail:*** Attn: Claim Processing 1936, 11825 N. Pennsylvania St., Carmel, IN 46032
- ***Fax:*** (317) 208-8656

SECTION A: INSURED/OWNER'S INFORMATION (please print)		
Policy number		
Last name	First name	Middle initial
Date of birth	Social Security number	
Mailing address ☐ Check box if this is a new permanent address ☐ Check box if address change applies to everyone on the policy		
City	State	ZIP code
If mailing address is a P.O. Box, please indicate physical address here		
Email		
Primary phone number	May we leave a voice mail? ☐ Yes ☐ No	

SECTION B: INSURED'S ADDRESS INFORMATION (if different from Owner)		
Last name	First name	Middle initial
Social Security number	Primary phone number	Date of birth
Mailing address		
City	State	ZIP code

SECTION C: PATIENT INFORMATION

Please describe your current health condition.

Are you currently receiving regular assistance with these Activities of Daily Living? ☐ Yes ☐ No
Please indicate the level of human assistance you require with the following Activities of Daily Living:

Activities of Daily Living	Care Currently Being Received	Independent	Requires Standby Assistance (within arm's reach)	Requires Hands on Assistance (physical assistance)
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
Continence	☐	☐	☐	☐
Eating	☐	☐	☐	☐

Please indicate the benefits you are requesting:

☐ **Monthly Option**:
3% of the Rider Benefit is paid every month (up to the HIPAA per diem limit x 30)

☐ **Lump Sum Option**:
An accumulation of the present value of 6* monthly benefit amounts. Paid every 6 months.

**If benefit period is less than 6 months, the lump sum benefit amount will be an accumulation of all monthly payments that would be paid in that benefit period. Payments are made at the beginning of the benefit period.*

NOTE: Recertification of qualification may be requested annually.

By signing my name on this document, I declare that all information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of signing this form.

_____ _____ ____/____/____
Patient signature (or legal representative) Relationship to Policyowner Date

_____ ____/____/____
Policyowner (or legal representative) Date

SECTION D: LICENSED HEALTHCARE PRACTITIONER STATEMENT

Must be completed and signed by the licensed healthcare practitioner (as defined in Section 1861(r)(1) of the Social Security Act)

Patient name	Patient date of birth

LICENSED HEALTHCARE PRACTITIONER INFORMATION

Name	Phone number	Fax number
Mailing address		
City	State	ZIP code

Are you related to the patient or have a financial interest in the payment of a benefit to the patient? ☐ Yes ☐ No
If yes, please explain:

Date of first treatment for primary condition. Month _____ Day _____ Year _____
By whom? (Name and Address)

Please check one of the boxes below regarding Severe Cognitive Impairment:

Severe Cognitive Impairment: Deterioration or loss in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in the Insured's:
1. Short or long-term memory; and
2. Orientation as to people, place, or time; and
3. Deductive or abstract reasoning.

a. ☐ There is no indication of a "Severe Cognitive Impairment."

b. ☐ There is an indication of a cognitive impairment, but does not meet the definition of a "Severe Cognitive Impairment."

c. ☐ There is a "Severe Cognitive Impairment" reflected in physician visit notes and/or cognitive testing. If you certify this individual as having a "Severe Cognitive Impairment", **please attach supporting medical records**.

Is the patient currently receiving regular assistance with Activities of Daily Living? ☐ Yes ☐ No

Is substantial supervision required to protect the patient from threats to his/her health or safety? ☐ Yes ☐ No

Is the patient currently receiving regular assistance with any of the Activities of Daily Living? ☐ Yes ☐ No

Please indicate the level of human assistance your patient requires with the following activities:

Activities of Daily Living	Care Currently Being Received	Independent	Requires Standby Assistance (within arm's reach)	Requires Hands on Assistance (physical assistance)
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
Continence	☐	☐	☐	☐
Eating	☐	☐	☐	☐

_____ ____/____/_____ _____

Licensed Healthcare Practitioner's signature Date Tax ID number

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.

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA, DELAWARE, FLORIDA, IDAHO: 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 deceive 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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