Bankers Conseco Life Insurance Company

BANKERS LIFE®

FILING A LONG-TERM CARE/SHORT-TERM CARE (LTC/STC) INSURANCE CLAIM WITH BANKERS CONSECO LIFE INSURANCE COMPANY

To provide clarity in filing a claim, this claim information packet is designed to provide you with straightforward instructions on how to file a claim under your Long-Term Care/Short-Term Care policy.

CLAIM FILING INSTRUCTIONS

Follow the four steps outlined below to file your claim.

Step 1: Contact our Intake Team at 1 (800) 845-5512

Working with an Intake Specialist will provide our claims team with valuable information to personalize your claim experience. Intake Specialist work with you one-on-one to answer your questions, walk you through your policy benefits, and assist you with the claim filing process.

The Intake Team is available between the hours of 8:00 AM – 4:30 PM Central Time, Monday through Friday. Intake Specialists can help answer questions such as:

- What types of services and expenses does my policy cover?
- Can you help me find qualified providers in my area?
- How would I qualify for benefits under my policy?
- What information/documents do I need to submit to receive reimbursement?
- How quickly can I expect a decision on my claim?
- What is an Elimination Period? Deductible? Waiver of Premium?

Step 2: Fill out claim form

The claim form begins your claims process. It is your opportunity to provide our claims team the necessary information to move your claim forward. Keep the following items in mind:

- Please note that care must begin before a claim can be submitted.
- Answer the questions as completely as possible. The more complete the information provided to us, the more efficiently we can process your claim. Feel free to attach additional pages if you need more room to respond.

Step 3: Provide authorization forms

These completed and signed forms will allow our claims team to request information on your behalf and provide updates to your authorized parties.

- The Claims Authorization for Medical Information form allows us to request information from your healthcare providers.
- The Voluntary Authorization to Disclose information to Third Party form allows us to provide information to your designated parties.
- Include a complete copy of your Power of Attorney document, if applicable.

Step 4: Submit documentation

You have three options for submitting claims documentation:

Submit Electronically	Submit by Fax	Submit by Mail
https://www.bankerslife.com/service-support/document-upload/	(312) 396-5952	Policy Benefits Department PO Box 1902 Carmel, IN 46082-1902

Step 5: What to expect after submitting your claim

Below is a list of items we will request directly from your care provider. If there are questions regarding your claims submission, or if additional information is required, you and/or your provider will be contacted within three weeks.

Nursing Home

- ☐ **Minimum Data Set (MDS)**: A standardized assessment completed by Nursing Home staff.
- ☐ **Facility's Service Plan:** A written plan of services to be provided.
- ☐ **Itemized Bill(s):** Please include the Medicare, Medicare Replacement or any Government Insurance explanation of benefits when applicable. Please submit the attached Proof of Residence form along with all bills.
- ☐ **Facility License:** A document showing that the Facility is licensed or certified.

Assisted Living Facility

- ☐ **Facility's Service Plan:** A written plan of services to be provided.
- ☐ **Medication Administration Record (MAR):** A daily record of medications administered.
- ☐ **Itemized Bill(s):** Please include any Government Insurance explanation of benefits when applicable. Please submit the attached Proof of Residence form along with all bills.
- ☐ **Facility License:** A document showing that the Facility is licensed or certified.

Home Health Care Provider

- ☐ **Plan of Care:** A written plan of services to be provided.
- ☐ **Initial Patient Assessment**: A written summary of medical conditions and history.
- ☐ **Daily Visit Notes:** Daily documentation of care provided.
- ☐ **Itemized Bill(s):** Please include the Medicare, Medicare Replacement or any Government Insurance explanation of benefits when applicable.
- ☐ **Agency License:** A document showing that the Agency is licensed or certified.

**Please use Independent Caregiver Packet for private/non-agency caregivers. This can be found on our website at Bankerslife.com or by calling our Customer Service Department at 1(800) 845-5512*

Adult Day Care Provider

- ☐ **Plan of Care:** A written plan of services to be provided.
- ☐ **Itemized Bill(s):** Please include any Government Insurance explanation of benefits when applicable.
- ☐ **Facility License:** A document showing that the Facility is licensed or certified.

*Note: If the claim involves care due to a Cognitive Impairment (ie Dementia, Alzheimer's, Memory Loss), we may request cognitive testing, *including but not limited to Mini Mental State Exam (MMSE), and relevant medical records along with the information listed above.*

Step 6: Create your profile on My.BankersLife.com (Optional)

Your profile is a great way to manage your payments, request documents, view recent claims, and much more!

Questions

If you have additional questions, please contact our Customer Service department Monday through Friday between 8:00 AM – 6:00 PM Central Time at 1(800) 845-5512, or visit our website at www.bankerslife.com.

1. CLAIMANT'S INFORMATION

List ALL long-term care/short-term care policy numbers under which you want to file a claim:

Policy #:_____ Policy #:_____ Policy #:_____ Policy #:_____

Claimant Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Contact Number:_____ Secondary Contact Number:_____

Disclaimer: If you wish to make a change to your address on file, you must fill out Section 2 below: "Address Change Request.

2. ADDRESS CHANGE REQUEST - Please complete only if you would like to change your mailing address.

☐ *Check this box if you would like to change your address of record and send all future correspondence related to this policy which includes Explanations of Benefits, renewal notices, etc. to:*

Street (and Apt. #) or P.O. Box:_____

City:_____ State:_____ Zip:_____

3. ALTERNATE CONTACT PERSON

Contact Person's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Relationship:_____

Do you want this person to be the primary contact for your claim? ☐ Yes ☐ No

If yes, please complete and include a "Voluntary Authorization to Disclose Information to Third Party" form, so we can share information about your claim with this individual.

Is this person a: ☐ Power of Attorney ☐ Conservator ☐ Guardian ☐ Other legal representative?

If so, please submit the documentation.

4. CLAIM INFORMATION

Reason for care: _____

Primary diagnosis(es) (for this claim): _____

Were you in the hospital within 30 days prior to receiving long-term care services? ☐ Yes ☐ No

Admit Date: _____ Discharge Date: _____

Hospital Name: _____ Hospital Phone Number: _____

What type of services are you requesting benefits for at this time? *Note: Care must have already started.*

☐ Home Health Care ☐ Adult Day Care ☐ Hospice ☐ Respite ☐ Nursing Home

☐ Assisted Living Facility ☐ Other: _____

Name of Facility/Agency: _____ Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Admit Date: _____ Discharge Date: _____ Is care on-going: ☐ Yes ☐ No

Date(s) you are filing from, if different than admit date: _____

What type of services are you requesting benefits for at this time? *Note: Care must have already started.*

☐ Home Health Care ☐ Adult Day Care ☐ Hospice ☐ Respite ☐ Nursing Home

☐ Assisted Living Facility ☐ Other: _____

Name of Facility/Agency: _____ Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Admit Date: _____ Discharge Date: _____ Is care on-going: ☐ Yes ☐ No

Date(s) you are filing from, if different than admit date: _____

5. PHYSICAN INFORMATION (Please include neurologist, gerontologist, etc. if applicable)

Name of Primary Care Physician: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Condition(s) treated: _____

Date of first visit: _____ Date of most recent visit: _____

Name of Primary Care Physician: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Condition(s) treated: _____

Date of first visit: _____ Date of most recent visit: _____

Name of Primary Care Physician: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Condition(s) treated: _____

Date of first visit: _____ Date of most recent visit: _____

6. GOVERNMENT INSURANCE INFORMATION

Do you currently have medical care under:

Medicare ☐ Yes ☐ No	**Tricare** ☐ Yes ☐ No	**Veteran Affairs** ☐ Yes ☐ No	**Medicaid** ☐ Yes ☐ No
Is Medicare providing payment for any of the services you are filing for? ☐ Yes ☐ No Do you have: ☐ Part A only ☐ Part B only ☐ Parts A & B ☐ Part C (Advantage)	Is Tricare providing payment for any of the services you are filing for? ☐Yes ☐No	Is Veterans Affairs providing payment for any of the services you are filing for? ☐Yes ☐No	Is Medicaid providing payment for any of the services you are filing for? ☐Yes ☐No

**Please submit any applicable Explanation of Benefits for any of the above.*

For your protection some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. If we determine that benefits have been paid under this coverage as a result of your fraudulent action(s), we have the right to recover those benefit amounts. We may recover those benefit amounts directly from you or by reducing any subsequent benefit payments under this coverage. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

I declare that all of the above answers are complete and true to the best of my knowledge and belief. I understand that the company reserves the right to require further proof.

Signature of Policyholder (or Legal Representative) _____ Date signed (Month/Day/Year) _____

Policyholder (or Legal Representative) Name (Please Print) _____ Signed at (City, County, State) _____

If Legal Representative, give relationship to Policyholder: _____

CLAIMS AUTHORIZATION FOR MEDICAL INFORMATION

CONFORMS TO HIPAA PRIVACY RULE

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

Printed Name: _____ Date of Birth: _____

Soc. Sec. Number (Last 4 Digits): _____ Policy Number: _____

Address: _____

City: _____ State: _____ Zip: _____

2. Disclosing Party – the party or 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 or governmental agency

3. Description of my information authorized for release

Any/all 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

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 – the parties authorized to receive information about me

- ☐ Bankers Life and Casualty Company, its agents, representatives and reinsurers
- ☐ Bankers Conseco Life Insurance Company*, its agents, representatives and reinsurers

*domiciled 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: LTC Claims Administration P.O. Box 1902, Carmel, IN 46082-1902. 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 800-621-3724 to request form 18727-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

VOLUNTARY AUTHORIZATION TO DISCLOSE INFORMATION TO THIRD PARTY

PURSUANT TO THE HIPAA PRIVACY RULE - FOR USE IN CONJUNCTION WITH LONG TERM CARE POLICIES ONLY

I. My Information – The individual whose information will be released

Printed Name: _____ Date of Birth: _____

Policy Number: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

II. Disclosing Party – Organization authorized to release my information

Bankers Life and Casualty Company*, Bankers Conseco Life Insurance Company**, Washington National Insurance Company*

*not licensed in the State of New York
**domiciled in and licensed in the State of New York

III. Description of my information authorized for release

☐ All information pertaining to my insurance transactions, claims and coverage including health and financial information

☐ Only information pertaining to: _____

IV. Purpose of release – Describing how my information will be used by the Receiving Party after it is released

At the request of the individual identified above.

V. Duration of authorization

This authorization will expire 12 months from the date written below, unless I specify an alternate expiration date here: _____

VI. Receiving Party – Individual(s) or organization(s) authorized by me to receive my information

Name: _____ Company Name (if applicable): _____

Address: _____ Telephone: _____

Name: _____ Company Name (if applicable): _____

Address: _____ Telephone: _____

VII. Approval – Signed and dated by me or my legal representative

- I understand that this authorization to release information to a third party is optional and I am not required under the terms of my policy to give such authorization.
- I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by sending a written revocation to the address below.
- I understand that my treatment, payment and eligibility for benefits may not be conditioned on this authorization.
- I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, it could be re-disclosed and no longer protected by federal health information privacy laws.
- I understand that I or my legal representative are entitled to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

_____ _____

Printed Name Relationship

_____ _____

Signature Date Signed

*Legal Representatives must provide documentation of legal authority

VIII. Return Signed And Dated Form

Long Term Care Claims - P.O. Box 1902, Carmel IN 46082-1902 Phone: (800) 845-5512 Fax: (312) 396-5952

PROOF OF RESIDENCE

Resident Name: _____ Policy #: _____

Facility Name: _____

Facility Address: _____ Resident's Room #: _____

Move-In Date: _____ Facility contact's name & number: _____

Facility Phone #: _____ Facility Fax #: _____

Fraud Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, files a claim or materials in support of a claim containing false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties.

Instructions:

- The Proof of Residence Form must be completed in its entirety by facility staff.
- Ensure copies of current blank Proof of Residence Forms are maintained by the facility.
- Complete this form for each month, after the last day of the month, after the services have been provided.
- Submit with a copy of the facility's invoice reflecting room and board charges for the month.
- Incomplete forms and photocopies of a prior month's completed Proof of Residence Form will be considered ineligible and may delay the reimbursement process.
- The completed form, with a copy of the corresponding bill, can be mailed, faxed or uploaded.

1. Billing Period - Attached billing invoice:

From: _____ To: _____ Is the resident deceased? ☐ Yes ☐ No

If yes, please provide date of death: _____ Was the resident charged for services on the date of death? ☐ Yes ☐ No

2. Was the Resident/Patient absent from the facility overnight at any time during this billing period? ☐ Yes ☐ No

If yes, please fill out below sections:

Departure Date: _____ Return Date: _____ Was the resident charged for either day? ☐ Yes ☐ No

If yes, which date(s): _____

Bed Hold Charge: ☐ Yes ☐ No If yes, daily amount: $ _____

Provide reason for absence: _____

3. Please explain any credits appearing on the current bill: _____

_____

4. Is Medicare, Medicaid, or any other insurance providing benefits for service during this period?

☐ Medicare ☐ Medicaid ☐ Other government insurance: _____

Please provide dates of 100% coverage/coinsurance/private pay below. Please include Explanation of Benefits or UB-04 form along with the bills and this form.

I verify that I am authorized to provide this information and that my statements are true and accurate to the best of my knowledge.

Printed Name & Title

Telephone number:

Signature

Date Signed

Submit Electronically	Submit by Fax	Submit by Mail
https://www.bankerslife.com/service-support/document-upload/	Policy Benefits Department (312)-396-5952	Policy Benefits Department PO Box 1902 Carmel IN 46082-1902

AK residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ 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.

AL residents: 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.

AR / LA and RI residents: 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.

CA residents: For your protection California 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.

CO 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.

DC 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.

DE residents: A person who knowingly and with intent to injured, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

FL 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.

ID residents: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN residents: A 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.

KY residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claiming 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.

MD residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME / TN / VA and WA 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 include imprisonment, fines and denial of insurance benefits.

MN residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH residents: Any person who, with the 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, as provided in N.H. Rev. Stat. Ann. 638:20.

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

NM residents: 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 civil fines and criminal penalties.

NY 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.

OH residents: 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.

OK residents: 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.

PA 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.

PR 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. Should aggravated circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TX residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

WV residents: 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.

All other states residents: 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.

Bankers Life is the marketing brand of Bankers Life and Casualty Company. Medicare Supplement insurance policies sold by Colonial Penn Life Insurance Company and select policies sold in New York by Bankers Conseco Life Insurance Company (BCLIC). BCLIC is authorized to sell insurance in New York.

(02/19) 190586

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