



Group Supplemental Hospital Confinement Indemnity Claim Form and Instructions

To file a claim for the **Doctor's Office/Urgent Care/Emergency Room Visit** Benefit, the **Preventive Care Test** Benefit, the **Diagnostic Tests 1 or 2** Benefit or the **Prescription** Benefit, **complete page 4 only**. Attach a copy of bills showing the medical expenses incurred and fax or mail as listed on the top of the claim form.

To file a claim for an **Accidental Injuries** Benefit (Ambulance, Dislocation, Emergency Dental Work, or Fracture), complete **Section A** and **Section B**, located on page 2.

To file a claim for the **Surgery with Anesthesia** Benefit, complete **Section A** on page 2 and **Section C** on page 3.

To file a claim for the **Hospital Confinement or Hospital Intensive Care Unit Confinement** Benefit, complete **Section A** on page 2 and **Section D** on page 3.

To file a claim due to **Accidental Death**, call **1.800.325.4368** and request a claim form for loss of life.

To avoid delays, be sure to answer all questions that apply to your specific claim.

- **Ask your doctor to complete his section**, where applicable.
- **Attach a copy of your bills showing the medical expenses incurred as requested under each section.**
- **Sign and date the enclosed authorization form.**

To avoid mail delays:

- You may **fax** your claim to Colonial Life at 1.800.248.9312. **If your claim is faxed, keep the original claim form and other documents for your records—do not mail them to Colonial Life.** Please allow at least 48 hours for our automated service center to be updated with information concerning receipt of your fax.
- Have your payment returned by **overnight delivery** by initialing the Optional Service Release Agreement below. A \$18.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increase by overnight carriers. Your check will be sent overnight to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments of \$100.00 or more. A street address is required. Your check will be delivered Monday through Friday; however, the time is not guaranteed.**

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below as indicated.

_____ I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by releasing its details with a **local sales representative** if he/she is inquiring on my behalf.

_____ I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by discussing its details with my **plan administrator** if he/she is inquiring on my behalf.

_____ Yes, please deduct the \$18.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from my claim payment for this claim. I understand this fee will be deducted for **future payments for this loss** and payments overnighted as well, unless I notify the company in writing to use normal mail service. I understand payments under \$100.00 will be sent by regular mail.

_____ Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying Colonial Life in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by us.

_____ Benefits are payable to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called an assignment of benefits. If you wish to assign your benefits, please attach a signed written request.

_____ If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

Certification: 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 Warning and State Versions" 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. 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 materials thereto commits a fraudulent insurance act, which is a crime.

Date (mm/dd/yyyy)

Certificate Holder's Signature

Patient's Signature

Print Certificate Holder's Name

Certificate Holder's Social Security Number

Mail to: Colonial Life & Accident Insurance Company
P. O. Box 100195
Columbia, SC 29202-3195

FAX to: 1.800.248.9312
If you fax your claim, please do not mail the original; keep it for your records.

Group Supplemental Hospital Confinement Indemnity Claim Form

Please check the type of benefit you are claiming.

- Accidental Injuries Benefit** (ambulance, dislocation, emergency dental work, fracture). Complete Sections A and B.
- Surgery with Anesthesia Benefit**. Complete Sections A and C.
- Hospital Confinement/Hospital Intensive Care Unit Confinement Benefit**. Complete Sections A and D.

Section A: Claimant Section

This claim is for: Self Spouse Dependent Certificate Number: _____

Name of Claimant: _____ Name of Certificate Holder (if not claimant): _____

Social Security Number: _____ Social Security Number: _____

Date of Birth (mm/dd/yyyy): ___/___/_____ Male/Female Date of Birth (mm/dd/yyyy): ___/___/_____ Male/Female

Has your address changed since we last heard from you? Yes No

Mailing Address: _____
P. O. Box _____ City _____ State _____ Zip _____

Street Address: _____
Street Address (Apartment/Unit Number) City State Zip

Home Phone Number: (_____) _____ Work Phone Number: (_____) _____

Fax Number: (_____) _____ Policyholder E-mail Address: _____

Section B: Accidental Injuries Benefit: These benefits are only payable for covered accidents.

Refer to your certificate for required proof of loss requirements.

Date of Accident (mm/dd/yyyy): ___/___/_____ Time of Accident _____ a.m./p.m. On-Job Accident Off-Job Accident

Description of Accident: _____

Treating Doctor's Name: _____ Phone Number: (_____) _____

Doctor's Address: _____
Street Address (Office/Unit Number) City State Zip

Ambulance: Attach a copy of the bill showing the charges incurred from the professional ambulance service.

Ask your medical provider to complete the following section. Include a copy of the bill(s) showing the medical expenses incurred and submit a copy of the operative report. If surgery was performed with anesthesia, also complete Section C on page 3.

Fractures/Dislocations:

Diagnosis/ICD-9 Code(s): _____ Treatment Procedure Code: _____ Treatment/Surgery Date: _____
Circle one: Anesthesia/Without Anesthesia Circle one: Inpatient/Outpatient

Diagnosis/ICD-9 Code(s): _____ Treatment Procedure Code: _____ Treatment/Surgery Date: _____
Circle one: Anesthesia/Without Anesthesia Circle one: Inpatient/Outpatient

Diagnosis/ICD-9 Code(s): _____ Treatment Procedure Code: _____ Treatment/Surgery Date: _____
Circle one: Anesthesia/Without Anesthesia Circle one: Inpatient/Outpatient

Emergency Dental Work: (Dental work must be the result of injuries received in a covered accident.)

Attach a copy of the bill showing the medical expenses incurred.

Circle whether emergency dental work resulted in: Extractions/Crowns/Treatment/Surgery Date: _____

Doctor's/Dentist's Signature (completing this form): _____ / ___/___

Tax ID or SSN: _____ Phone Number: (_____) _____ Fax Number: (_____) _____

Claimant Name: _____

Social Security Number: _____

Section C: Surgery with Anesthesia Benefit:

Refer to your certificate for required proof of loss requirements.

Date of Accident (mm/dd/yyyy): ____/____/____ Time of Accident _____ a.m./p.m. On-Job Accident Off-Job Accident

If claim is due to an accident, provide a description of the accident: _____

Description of medical/health condition being treated: _____

Treating Surgeon's Name: _____ Phone Number: (____) _____

Surgeon's Address: _____
Street Address (Office/Unit Number) City State Zip

Ask your surgeon to complete the following section. Include a copy of the bill(s) showing the medical expenses incurred and submit a copy of the operative report.

Primary Diagnosis/ICD-9 Code: _____ Secondary Diagnosis/ICD-9 Code(s): _____

Surgical Procedure Code(s): _____ Surgery Date: ____/____/____

Any prior treatment for same/similar condition? Yes No Dates of prior treatment: _____

Referring Doctor's Name: _____ Phone Number: (____) _____

Referring Doctor's Address: _____
Address (Office/Unit Number) City State Zip

Doctor's Signature (completing this form): _____

(mm/dd/yyyy)

Tax ID or SSN: _____ Phone Number: (____) _____ Fax Number: (____) _____

Section D: Hospital Confinement/Hospital Intensive Care Unit Confinement Benefit:

Refer to your certificate for required proof of loss requirements.

Date of Accident (mm/dd/yyyy): ____/____/____ Time of Accident _____ a.m./p.m. On-Job Accident Off-Job Accident

If claim is due to an accident, provide a description of accident: _____

Description of medical/health condition being treated: _____

Hospital Name: _____ Phone Number: (____) _____

Hospital Address: _____
Street Address City State Zip

Admitting Doctor's Name: _____ Phone Number: (____) _____

Admitting Doctor's Address: _____
Street Address (Office/Unit Number) City State Zip

Ask your treating medical provider to complete the following section. Include a copy of the hospital bill(s) showing the admission and discharge dates, the daily room charge(s) and the medical expenses incurred.

Hospital Confinement: ____/____/____ to ____/____/____ Intensive Care Unit Confinement: ____/____/____ to ____/____/____
Dates: (mm/dd/yyyy) (mm/dd/yyyy) Dates: (mm/dd/yyyy) (mm/dd/yyyy)

Admitting Diagnosis/ICD-9 Code: _____ Secondary Diagnosis/ICD-9 Code(s): _____

Any prior treatment for same/similar condition? Yes No Dates of prior treatment: _____

If hospital confinement is for pregnancy or pregnancy complications, please provide the date the pregnancy was diagnosed: ____/____/____

Date of Delivery: ____/____/____ Type of Delivery: Vaginal Cesarean Procedure Code for Delivery: _____

Referring Doctor's Name: _____ Phone Number: (____) _____

Referring Doctor's Address: _____
Address (Office/Unit Number) City State Zip

Doctor's Signature (completing this form): _____

(mm/dd/yyyy)

Tax ID or SSN: _____ Phone Number: (____) _____ Fax Number: (____) _____

Mail to: Colonial Life & Accident Insurance Company
P. O. Box 100195
Columbia, SC 29202-3195

FAX to: 1.800.248.9312
If you fax your claim, please do not mail the original; keep it for your records.

**Group Supplemental Hospital Confinement Indemnity Express Filing Form for:
Doctor's Office/Urgent Care/Emergency Room Visit Benefit,
Preventive Care Test Benefit, Diagnostic Tests Benefit, or the Prescription Benefit**

This claim is for: Self Spouse Dependent Certificate Number: _____
Name of Claimant: _____ Name of Certificate Holder (if not claimant): _____
Social Security Number: _____ Social Security Number: _____
Date of Birth (mm/dd/yyyy): ____/____/____ Male/Female Date of Birth (mm/dd/yyyy): ____/____/____ Male/Female
Has your address changed since we last heard from you? Yes No
Mailing Address: _____
P. O. Box _____ City _____ State _____ Zip _____
Street Address: _____
Street Address _____ (Apartment/Unit Number) _____ City _____ State _____ Zip _____
Home Phone Number: (____) _____ Work Phone Number: (____) _____
Fax Number: (____) _____ Policyholder E-mail Address: _____

Doctor's Office/Urgent Care/Emergency Room Visit Benefit

Claim due to: Accident Sickness Condition being treated: _____
Date of Accident (mm/dd/yyyy): ____/____/____ Time of Accident: _____ a.m./p.m.
Description of Accident: _____

Include a billing statement from your physician, medical practitioner, hospital, clinic, or medical facility that includes:
* Patient's Name * Date of Treatment * Diagnosis/Diagnosis Code * Total Charge Incurred

Preventive Care Test Benefit

Include a billing statement from your physician, medical practitioner, hospital, clinic, or medical facility that includes:
* Patient's Name * Date of Treatment * Diagnosis/Diagnosis Code * Total Charge Incurred * Type of Test Performed

Diagnostic Test Benefit (Part 1 and/or Part 2)

Claim due to: Accident Sickness Condition being treated: _____
Date of Accident (mm/dd/yyyy): ____/____/____ Time of Accident: _____ a.m./p.m.
Description of Accident: _____

Include a billing statement from your physician, medical practitioner, hospital, clinic, or medical facility that includes:
* Patient's Name * Date of Treatment * Diagnosis/Diagnosis Code * Total Charge Incurred * Type of Test Performed

Prescription Benefit (This benefit is not for medication that does not require a prescription).

Medication (1): _____ Condition being treated: _____
Medication (2): _____ Condition being treated: _____
Medication (3): _____ Condition being treated: _____

Attach a copy of the pharmacy detailed receipt or mail order pharmaceutical statement showing:

* Patient's Name * Name of Prescription Drug * Date the Prescription was filled * Total Charge Incurred

Certification:

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.

(mm/dd/yyyy)

Certificate Holder's Signature

Patient's Signature

Claim Fraud Warning and State Versions

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.

Resident State State Version of Fraud Warning

Alaska	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.
Arkansas	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	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	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.
Colorado	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	<i>WARNING:</i> 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.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
Florida	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.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
Indiana	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.
Kentucky	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.
Louisiana	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.
Maine	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.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of 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.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Resident State State Version of Fraud Warning

New Hampshire	Any person who, 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, as provided in RSA 638.20.
New Jersey	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New Mexico	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.
New York	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.
Ohio	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.
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.
Oregon	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.
Pennsylvania	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.
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 (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.
Tennessee	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.
Texas	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.
Virginia	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.
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.
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.