Colonial Life

Critical Illness Claim

FAX this direction	FAX this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia SC 29202	From:	
		Number of pages:	

Optional Service Release Agreement

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the following individual inquiring on my behalf.
Note: Leave blank if you do not want anyone accessing your claim information.

_____ Sales representative _____ Employer _____ Spouse, family member or significant other Name: _____

_____ I want Colonial Life to update me on the status of my claim through electronic messaging at my contact number indicated on this form. I understand that messages will be left with anyone who answers the phone or on my answering machine. Note: To avoid blocked calls, you should program the number 1-800-325-4368 into your phone.

_____ **Yes, I want ALL payment(s) for this claim sent by overnight delivery.** I understand payment(s) under $100.00 cannot be sent overnight. I also understand that if I wish my claim to be sent by overnight delivery, a **$22.00 fee** will be deducted from my claim payment. This fee is subject to rate increases by carrier and does not include weekend delivery. **I understand that Colonial Life is unable to send overnight mail to a P.O. Box. I also understand that I must notify Colonial Life to discontinue this service.**

Incomplete claim form submission may result in a delay in the processing of your claim.
Complete each section before submitting your claim.

- If your name has changed, attach a copy of your driver's license or other legal documentation.
- Dates should be written in month/day/year format (i.e. 12/14/1980).
- Social Security number is indicated by SSN.
- Benefits are payable to you unless we receive written authorization to pay them elsewhere. This is called an assignment.
- 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.

Section 1 – Claimant statement (completed by policy owner)

Claimant name:	☐ Male ☐ Female	DOB: ____/____/_____	SSN:
Relationship to policy owner: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent			
Policy owner information (if other than claimant) — Name:		DOB: ____/____/_____	SSN:
Address:	City:	State:	ZIP:
Email:		Contact number:	
Type of illness are you claiming:	Date you were first treated for the illness: _____/_____/_____		
Do you have a disability policy with us? ☐ Yes ☐ No	Employer name:		
Employer telephone:	Employer fax:		

Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others, require the following statement to appear on this claim form. **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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

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, Rhode Island, Texas and West Virginia: For your protection, California, Rhode Island, Texas and West Virginia 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: 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.

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.

Kentucky: For your protection, Kentucky law requires the following to appear on this 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 material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland: 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.

New Jersey and New Mexico: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil 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.

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.

Policy owner name:		**Policy owner SSN:**
If other than policy owner	**Claimant name:**	**Claimant SSN:**

Section 1 – Claimant statement ~ continued (completed by policy owner)

Treating physician	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	
Primary physician	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	
Referring physician/hospital	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	

Hospital admission: ☐ Yes ☐ No

Treating hospital:		Telephone:	
Address:	City:	State:	ZIP:

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Treating hospital:		Telephone:	
Address:	City:	State:	ZIP:

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Select the condition for this claim

Please note that coverage for the conditions listed below depends on your specific policy. Some policies may provide a benefit for a dependent child diagnosed with Cerebral Palsy, Cleft Lip or Palate, Cystic Fibrosis, Down Syndrome or Spina Bifida. If filing for a dependent with one of these conditions, the claimant name in all sections of this form should be the dependent's name. Please include a completed Physician's Statement (Section 2 in this form) or other information that confirms the diagnosis. Review your policy for specific conditions and documentation required.

CONDITION	EXAMPLES OF MEDICAL DOCUMENTATION THAT MAY BE REQUIRED
☐ Blindness (if applicable to your policy)	Medical documentation of clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or visual field restriction to 20 degrees or less in both eyes.
☐ Bypass surgery as a result of coronary artery disease	Surgical report that documents procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts.
☐ Cancer and/or carcinoma in situ	A pathology report confirming the pathological diagnosis of cancer or carcinoma in situ by a certified pathologist. If a pathological diagnosis cannot be made provide medical evidence to support a clinical diagnosis of cancer or carcinoma in situ based on the study of symptoms.
☐ Coma	Medical records substantiating the coma resulting from a covered accident or a covered sickness has lasted 7 or more consecutive days. In some policies intubation for respiratory assistance may also be required.
☐ Coronary artery disease	Medical documentation indicating a narrowing or blockage of one or more coronary artieries for which a cardiologist recommends that coronary artery bypass graft surgery occur within 60 days following the date of the recommendation.
☐ End stage renal failure	Medical documentation that documents the date regular hemodialysis or peritoneal dialysis began.
☐ Heart attack (myocardial infarction)	Diagnosis supported by three or more of the following indicators: medical records documenting typical chest pain suggestive of heart attack; new EKG report showing changes indicative of myocardial infarction; medical reports documenting increase of specific cardiac markers typical for heart attack, or medical reports of confirmatory imaging studies. (In the event of death, an autopsy confirmation identifying heart attack as the cause of death will be accepted.)
☐ Major organ failure/Major Organ Transplant	Medical documentation that the Insured has been placed on the United Network for Organ Sharing list. Some policies may require a copy of the transplant surgical report.
☐ Occupational Infections (HIV or Hepatitis B, C or D)	Provide the following: copy of report that was reported and recorded within five days of the covered accident by the appropriate person according to legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession; copy of investigated covered accident report filed with your employer that confirms events surrounding work-related injury; confirmatory antibody HIV or Hepatitis B, C or D test taken with five days of the Covered Accident and HIV or Hepatitis B, C or D is not present; all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the Covered Accident, and the result is positive.
☐ Permanent paralysis (due to covered accident) if applicable to your policy	Medical documentation of complete and permanent loss of the use of two or more limbs for a continuous period of 180 days.
☐ Stroke	Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event and confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.

Policy owner name:		**Policy owner SSN:**
If other than policy owner	**Claimant name:**	**Claimant SSN:**

Certification

Policy owner's name: _____ SSN: _____

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 Statements on page two of this 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. **Fraud Warning:** 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.

Print claimant's name	Claimant's signature	Date (MM/DD/YYYY)
Print policy owner's name	Policy owner's signature	Date (MM/DD/YYYY)

If deceased, attach a death certificate and complete below.

Beneficiary's name	Beneficiary's signature	Date (MM/DD/YYYY)

Beneficiary's SSN:	Beneficiary's DOB: _____ / _____ / _____		Relationship to deceased:
Beneficiary's address:			
City:	State:	ZIP:	Telephone:

Witness' name:	Witness' signature:		
Witness' address:	City:	State:	ZIP:

Section 2 – Physician statement (completed by physician)

Patient name:	SSN:	DOB: _____ / _____ / _____

Diagnosis(es)	Date of diagnosis (MM/DD/YYYY)	ICD-9 code(s)

Has patient been treated for same or similar condition prior to this occurrence? ☐ Yes ☐ No

Diagnosis	First date of treatment	Referring physician	Telephone

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes attending physician portions of the claim form.

Physician signature	Date (MM/DD/YYYY)

Physician/group name:		Tax ID or SSN:	
Physician's specialty:	Telephone:	Fax:	
Address:	City:	State:	ZIP:

Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non-health information, including earnings or employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms, may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance. Some information once obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not re-disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier, and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P.O. Box 100195, Columbia, SC 29202-3195.

I may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer my claim or eligibility for insurance.

I am the individual to whom this authorization applies or that person's legal guardian, power of attorney designee, conservator, beneficiary or personal representative.

_____ _____

Signature | Date signed (MM/DD/YYYY)

_____ XXX-XX-_____ _____

Printed name of individual subject to this disclosure | Last four digits of SSN | Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_____ _____ _____

Printed name of legal representative | Signature of legal representative | Date signed (MM/DD/YYYY)