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:	

File Your Claim Online

- ▶ Simply log into your account at Coloniallife.com and click on "File an Online Claim".
- ▶ As an added convenience, you may also select Direct Deposit when filing online.
- ▶ Not a member? Log onto Coloniallife.com and click on "Register" then "Join the Policyholder Website" to set up your account.

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 prerecorded messages 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.**

_____ **Yes, I want to Direct Deposit all payments into my bank account.** I have enclosed a voided check for a checking account or a deposit slip for a savings account with my initial claim submission. Please note: Allow up to three business days after claim payment for deposit into your account.

I also understand that I must notify Colonial Life to discontinue any of these services.

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 legal documentation of the change.
- 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.
- Anytime you are submitting a claim to us, please provide us with supporting documents from the provider related to the Critical Illness for which a claim is being made. The supporting documents must include: 1) the diagnosis; 2) pathology reports, surgical notes, lab results, or clinical records that support the diagnosis of the covered condition and 3) the date(s) of diagnosis.

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:	

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming 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.

California: 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: 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.

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

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 and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution 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:**

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:

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		

What Type of Condition Are You Claiming?

- Refer to your policy for a complete description of these benefits.
- Not all plans include these benefits.

Please check off the condition that applies to your claim:

CONDITION(S)	
☐ Benign Brain Tumor	Loss of: ☐ Hearing ☐ Sight ☐ Speech
☐ Blindness	
☐ Bypass surgery as a result of Coronary Artery Disease or Coronary Artery Bypass Graft Surgery (CABG)	
☐ Cancer (Invasive)	☐ Major Organ Failure/Major Organ Transplant
☐ Carcinoma in situ (Non-invasive Cancer)	☐ Occupational Infections (HIV or Hepatitis B, C or D)
☐ Coma	☐ Permanent Paralysis (due to covered accident)
☐ Coronary Artery Disease	☐ Stroke
☐ End Stage Renal (Kidney) failure	☐ Sudden Cardiac Arrest - due to Coronary Artery Disease, Cardiomyopathy, or Hypertension
☐ Heart Attack (Myocardial Infarction)	

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

OPTIONAL DISEASES AND PROCEDURES RIDERS

Heart Benefits Rider

- ☐ Abdominal Aortic Aneurysm Surgery
- ☐ Aortic Valve Replacement or Repair
- ☐ Mitral Valve Replacement or Repair
- ☐ Coronary Artery Bypass Graft Surgery
- ☐ Atherectomy
- ☐ Automatic Implantable (or internal) Cardioverter Defibillator (AICD)
- ☐ Balloon Angioplasty
- ☐ Heart Catherization
- ☐ Laser Angioplasty
- ☐ Pacemaker Placement
- ☐ Stent Implantation
- ☐ Thrombectomy (clot removal) using catheters such as AngioJet

Infectious Diseases Rider

- ☐ Antibiotic resistant bacteria (including MRSA)
- ☐ Cerebrospinal Meningitis (bacterial)
- ☐ Coronavirus Diseases 2019 (COVID-19)
- ☐ Diptheria
- ☐ Encephalitis
- ☐ Legionnaires' Disease
- ☐ Lyme Disease
- ☐ Malaria
- ☐ Necrotizing Fasciitis
- ☐ Osteomyletis
- ☐ Poliomyelitis
- ☐ Rabies
- ☐ Sepsis
- ☐ Tetanus
- ☐ Tuberculosis

Progressive Diseases Rider

- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Dementia (Including Alzheimer's Disease)
- ☐ Huntington's Disease
- ☐ Lupus
- ☐ Multiple Sclerosis (MS)
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Parkinson's Disease
- ☐ Systemic Sclerosis (Scleroderma)

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.

☐ Cerebral Palsy ☐ Cleft Lip or Palate ☐ Cystic Fibrosis ☐ Down Syndrome ☐ Spina Bifida

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: For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the 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.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalities. This includes the Physician Statement portion of the claim form.

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-a – Physician statement (completed by physician)

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

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.
CONDITION(S)	**PLEASE PROVIDE THE RELEVANT MEDICAL DOCUMENTATION AS NOTED BELOW.**
☐ Benign Brain Tumor	Date of biopsy or neuroradiological report confirming diagnosis of brain tumor: _____ (Submit a copy of the report confirming diagnosis.)
☐ Blindness	Documentation of clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days.
☐ Bypass surgery as a result of Coronary Artery Disease or Coronary Artery Bypass Graft Surgery (CABG)	Date CABG recommended: _____ Date CABG performed: _____
☐ Cancer (Invasive)	Was the cancer identified by the presence of malignant cells or a malignant tumor characterized by uncontrolled and abnormal growth and spread of invasive malignant cells? ☐ Yes ☐ No If yes, date diagnosed: _____ Pathology report or medical records supporting a clinical diagnosis of invasive cancer.
☐ Carcinoma in situ (Non-invasive Cancer)	Was the cancer classified as stage 0 or in-situ? ☐ Yes ☐ No Date diagnosed: _____ Pathology report or medical records supporting a clinical diagnosis of non-invasive cancer
☐ Coma	Medical records substantiating the coma resulting from an accident or a sickness lasting 7 or more consecutive days.
☐ End Stage Renal (Kidney) failure	Medical documentation that documents the date regular hemodialysis or peritoneal dialysis began. Date dialysis began _____
☐ Heart Attack (Myocardial Infarction)	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.
☐ Loss of Hearing	Does patient have irrecoverable loss of hearing in both ears following a period when the covered person had the ability to hear? ☐ Yes ☐ No If yes, date hearing loss certified by a physician:_____ (Send medical record/documentation that supports this finding.)
☐ Loss of Sight	Is the patient legally blind? Yes or No If yes, what date was the permanent reduction in sight certified by a physician following a period when the covered person was not legally blind? Date: _____ Visual Acuity (Snellen or E-Chart Acuity): Right Eye_____ Left Eye _____ Visual Field: Right Eye_____ Left Eye_____ (Send medical record/documentation that supports this finding.)
☐ Loss of Speech	Did patient have total and irrecoverable loss of speech following a period where they had the ability to speak? ☐ Yes ☐ No If yes, date physician certified the above: _____ (Send medical record/documentation that supports this finding.)
☐ Major Organ Failure/Major Organ Transplant	Date placed on United Network for Organ Sharing list. (UNOS) for transplant _____ If applicable: Date of transplant _____ Type of transplant _____
☐ Occupational Infections (HIV or Hepatitis B, C or D)	Provide a copy of the report that confirms the HIV antibody or positive Hepatitis B,C, or D test taken between 90 days and 180 days after the covered accident. Tests must be performed by a state certified and licensed laboratory.
☐ Permanent Paralysis (due to covered accident)	Medical documentation of complete and permanent loss of the use of two or more limbs for a continuous period of 180 days.
☐ Skin Cancer	Was skin cancer diagnosed? ☐ Yes ☐ No If so, was it: basal cell carcinoma, squamous cell carcinoma, melanoma Clark's I or less, or other:_____ Date diagnosed: _____ Send copy of pathology report confirming diagnosis.
☐ Stroke	Any continued deficits past 30 days: ☐ Yes ☐ No If yes, list deficits _____ Date of confirmatory neuroimaging studies _____
☐ Sudden Cardiac Arrest	Did patient have sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stopped working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension? Yes or No If yes, date of occurrence: _____ (Send medical record/documentation that supports this finding.)

Section 2-a – Physician statement - Continued (completed by physician)

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

Select the condition for this claim	Some policies may allow you to select an optional rider. If you are trying to file for a benefit covered under a rider, select the appropriate benefit.
OPTIONAL RIDERS	**EXAMPLES OF MEDICAL DOCUMENTATION THAT MAY BE REQUIRED**
Heart Benefits Rider ☐ Abdominal Aortic Aneurysm Surgery ☐ Aortic Valve Replacement or Repair ☐ Mitral Valve Replacement or Repair ☐ Coronary Artery Bypass Graft Surgery ☐ Atherectomy ☐ Automatic Implantable (or internal) Cardioverter Defibillator (AICD) ☐ Balloon Angioplasty ☐ Heart Catherization ☐ Laser Angioplasty ☐ Pacemaker Placement ☐ Stent Implantation ☐ Thrombectomy (clot removal) using catheters such as AngioJet	Procedure must be due to Acute Coronary Syndrome, Atherosclerosis, Coronary Artery Disease, Cardiomyopathy, or Valvular Heart Disease Date of Procedure _____ CPT Code _____
Infectious Diseases Rider ☐ Antibiotic resistant bacteria (including MRSA) ☐ Cerebrospinal Meningitis (bacterial) ☐ Coronavirus Diseases 2019 (COVID-19) ☐ Diptheria ☐ Encephalitis ☐ Legionnaires' Disease ☐ Lyme Disease ☐ Malaria ☐ Necrotizing Fasciitis ☐ Osteomyletis ☐ Polio ☐ Rabies ☐ Sepsis ☐ Tetanus ☐ Tuberculosis	Date of Diagnosis_____ ICD10_____ Dates of Hospital Confinement _____ to _____
Progressive Diseases Rider ☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Dementia (Including Alzheimer's Disease) ☐ Huntington's Disease ☐ Lupus ☐ Multiple Sclerosis (MS) ☐ Muscular Dystrophy ☐ Myasthenia Gravis ☐ Parkinson's Disease ☐ Systemic Sclerosis (Scleroderma)	Date of Diagnosis_____ ICD10_____ Date the patient was unable to perform 2 or more of the following ADLs due to this condition. _____ Check all that apply: ☐ ***Bathing*** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower. ☐ ***Continence*** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygience (including caring for catheter or colostomy bag). ☐ ***Dressing*** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs. ☐ ***Eating*** means feeding oneself by getting food into the body from a receptable (such as a plate, cup or table) or by a feeding tube or intravenously. ☐ ***Toileting*** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. ☐ ***Transferring*** means the ability to move in or out of a chair, bed or wheelchair.

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

Has the patient been hospitalized for this condition ☐ Yes ☐ No If yes: Date admitted _____ Date Discharged _____

Date admitted _____ Date Discharged _____

Hospital:		
Address:		
City:	State:	Zip:
Telephone:	Fax:	

Diagnosis	First date of treatment	Referring physician	Telephone

Section 2-a – Physician statement - Continued (completed by physician)

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

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:

Section 2-b – Physician statement - Continued (completed by physician if filing for disability)

Does patient have permanent restrictions and/or limitations? __Yes __No If yes, which ones are permanent:	Limitations (patient CANNOT DO):	Restrictions (patient SHOULD NOT DO):

Dates unable to work (full-time): From: _____ / _____ / _____ To: _____ / _____ / _____ |	Expected return to work: _____ / _____ / _____

Dates able to work (part-time):
From: _____ / _____ / _____ To: _____ / _____ / _____ Number of hours: _____ Actual return to work: _____ / _____ / _____

Did this condition require house confinement: ☐ Yes ☐ No If yes, From: _____ / _____ / _____ To: _____ / _____ / _____
House confinement means the patient is kept at home (in house or yard) by the condition. However, the patient may follow your orders, even if it means leaving home.

Check activities of daily living that the patient is unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence

Dates unable to perform activities of daily living: From: _____ / _____ / _____ To: _____ / _____ / _____

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:

Claimant name:	**Claimant SSN:**

Section 3 – Employer statement (completed by employer) (If filing for disability)

Employee name:	SSN:
Employee title:	Hire date: _____ / _____ / _____

Average number of scheduled hours per week:	Date last worked: _____ / _____ / _____	Date employment terminated: _____ / _____ / _____
Employee unable to work (Full-time): From: _____/ _____/ _____ To: _____/ _____/ _____		Sick leave was exhausted on: _____ / _____ / _____
Approved for FMLA (if eligible): From: _____/ _____/ _____ To: _____/ _____/ _____		Was employee at work when accident or sickness occurred? ☐ **Yes** ☐ **No**
Workers' compensation claim filed? ☐ **Yes** ☐ **No**	Workers' compensation carrier Name:	Telephone:

Hourly employee rate:	Hours worked per week:	Annual salary:	If paid on commission basis, attach commission breakdown for prior 12 months from date last worked.
Do you permit light duty for employee? ☐ **Yes** ☐ **No**		Do you permit partial duty for employee? ☐ **Yes** ☐ **No**	
Expected return to work: _____ / _____ / _____	Actual return to work: Full-time: _____ / _____ / _____	Actual return to work: Part-time: _____ / _____ / _____ Hours per week:_____	

Employee's duties include:	☐ **Sitting** _____ per hr. ☐ **Walking** _____ per hr. ☐ **Climbing stairs/ladders** _____ per hr. ☐ **Standing** _____ per hr. ☐ **Driving** _____ hrs. per day
	Lifting: ☐ Less than 15 lbs. ☐ 15 to 44 lbs. ☐ More than 45 lbs. **Stooping/bending:** ☐ none ☐ seldom ☐ frequent

Reaching/pulling/pushing: ☐ none ☐ seldom ☐ frequent **Crawling/kneeling:** ☐ none ☐ seldom ☐ frequent **Repetitive motion:** ☐ none ☐ seldom ☐ frequent

Contact for updates on return to work status:	Telephone:
Email:	Fax:

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 employer's portions of the claim form.

_____ Signature of authorized person	_____ Date (MM/DD/YYYY)
Title of authorized person:	Employer/company name:

Telephone:	Fax:	Email:

Authorization for Colonial Life & Accident Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

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 and its duly authorized representatives (Colonial Life).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms.

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, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. 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 or as authorized by me.

I also authorize Colonial Life to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Colonial Life; or, the Social Security Administration. Colonial Life will not condition the payment of insurance benefits on whether I authorize Colonial Life to re-disclose my information. For the purposes of these disclosures by Colonial Life, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), 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 I do not sign this authorization or if I alter or revoke it, except as specified above, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

_____ _____

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)