




Cancer Claim

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|---|--|------------------------|
|  FAX this direction | FAX this form: 1-800-880-9325 | From: _____ |
| | Or mail: P.O. Box 100195, Columbia, SC 29202 | 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 want 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 or holiday 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.

Wellness/health screenings If you wish to file a wellness/cancer screening claim for a test performed within the past 36 months, you'll need to submit the type and date of the test performed, as well as your physician's name and phone number. We also need to know if this is for you or another covered individual. If this is for another covered individual, we need his or her name and Social Security number. If you file by telephone or Internet, please retain a copy of the medical information and/or your receipt if needed for further verification.

- You may file by:**
- Phone: 1-800-325-4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week; or
 - Internet: File your claim online at Coloniallife.com or
 - Fax/mail: 1-800-880-9325 / P.O. Box 100195, Columbia SC 29202

Write your name, address, Social Security number and/or policy/certificate number on your bill and indicate "Wellness Test." If your wellness/cancer screening test was more than 36 months ago, you must fax or mail us a copy of the bill or statement from your physician indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, Social Security number and current address on the bill.

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

Please make sure that all written responses are legible.

- 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.
- The **pathology report** is required when filing the first cancer claim and any new diagnosis, including diagnosis of skin cancer.
- **Copies of any itemized bills** – surgeon, medical imaging, radiation/chemotherapy, hospital, etc. are required.
- Benefits are payable to you unless we receive written authorization to pay benefits 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)

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|--|--|---------------------|-------------------------|
| Claimant name: | <input type="checkbox"/> Male <input type="checkbox"/> Female | DOB: ____/____/____ | SSN: _____ |
| Relationship to policy owner: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Dependent | | | |
| Policy owner information (if other than claimant) | Name: | DOB: ____/____/____ | SSN: _____ |
| Address: | Apt. # | City: | State: _____ ZIP: _____ |
| Email: | Contact number: _____ | | |
| Date cancer was diagnosed: ____/____/____ | First cancer diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date: ____/____/____ | | |
| Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Prostate <input type="checkbox"/> Skin <input type="checkbox"/> Other: | Dates unable to work: From: ____/____/____ To: ____/____/____ | | |

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.

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| Claimant name: | Claimant SSN: |
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Section 1 – Claimant statement ~ continued (completed by policy owner)

If not employed, list dates of house confinement: From: ____ / ____ / ____ To: ____ / ____ / ____
 House confinement means you are kept at home (in house or yard) by the condition. However, you may follow your physician's orders, even if it means leaving home.

Have you been unable to perform activities of daily living? Yes No **If yes, list dates:** From: ____ / ____ / ____ To: ____ / ____ / ____

Check activities of daily living that you are unable to perform: Dressing Eating Meal preparation Bathing Transferring Toileting Continence

Date returned to work: Full-time: ____ / ____ / ____ Part-time: ____ / ____ / ____ If part-time, hours worked per week: _____

Hospital confinement: Yes No
 Admission date: ____ / ____ / ____ Time: ____ AM PM Date released: ____ / ____ / ____ Time: ____ AM PM

Please include an itemized hospital bill. If surgery was performed, submit an itemized surgeon's bill and anesthesia bill.

| | | | |
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| Hospital: | | Telephone: | |
| Address: | City: | State: | ZIP: |

List all physicians who have treated you for this condition.

| | | | |
|---------------------------|------------|--------|------|
| Primary physician: | Telephone: | Fax: | |
| Address: | City: | State: | ZIP: |
| Physician: | Telephone: | Fax: | |
| Address: | City: | State: | ZIP: |
| Physician: | Telephone: | Fax: | |
| Address: | City: | State: | ZIP: |
| Physician: | Telephone: | Fax: | |
| Address: | City: | State: | ZIP: |

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) |

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|-----------------------|----------------------|
| Claimant name: | Claimant SSN: |
|-----------------------|----------------------|

Section 2 – Employer statement (Completed by employer if also filing under a disability policy)

Have this section completed if the policy owner is disabled for 90 consecutive days due to cancer.

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| 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: ____ / ____ / ____ |
| Return to work: ____ / ____ / ____ | Actual return to work: Full-time: ____ / ____ / ____ | Actual return to work: Part-time: ____ / ____ / ____ Hours per week: |

Do you permit light or partial duty for employee?

| | |
|-----------------------------------|---|
| Employee's duties include: | <input type="checkbox"/> Sitting ____ per hr. <input type="checkbox"/> Walking ____ per hr. <input type="checkbox"/> Climbing stairs/ladders ____ per hr. <input type="checkbox"/> Standing ____ per hr. <input type="checkbox"/> Driving ____ hrs. per day <input type="checkbox"/> Lifting : <input type="checkbox"/> Less than 15 lbs. <input type="checkbox"/> 15 to 44 lbs. <input type="checkbox"/> More than 45 lbs. <input type="checkbox"/> Stooping/bending : <input type="checkbox"/> none <input type="checkbox"/> seldom <input type="checkbox"/> frequent |
|-----------------------------------|---|

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

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| 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.

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|---|----------------------------|
| _____ Signature of authorized person | _____ Date (MM/DD/YYYY) |
|---|----------------------------|

| | |
|-----------------------------|------------------------|
| Title of authorized person: | Employer/company name: |
| Telephone: | Fax: |
| Email: | |

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|-----------------------|----------------------|
| Claimant name: | Claimant SSN: |
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Section 3 – Physician statement (completed by physician)

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| Patient name: | DOB: ____ / ____ / ____ |
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What primary condition prevents the patient from working?

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| When did symptoms first appear? ____ / ____ / ____ Symptoms: | Date cancer diagnosed (attach pathology report): |
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List all dates patient received: medical advice, diagnosis or treatment for this condition (or a related condition) for the 18 months prior to this condition.

Date first treated for this condition: ____ / ____ / ____ All other dates (MM/DD/YYYY):

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| Are there secondary conditions preventing patient from working? <input type="checkbox"/> Yes <input type="checkbox"/> No | Secondary conditions: |
|--|-----------------------|

| | | |
|--|--|--|
| Date of patient's last visit: ____ / ____ / ____ | Date of patient's next scheduled visit: ____ / ____ / ____ | Date of new patient consultation: ____ / ____ / ____ |
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| Date of patient's next scheduled visit: ____ / ____ / ____ | How soon do you expect significant improvement in the patient's medical condition? <input type="checkbox"/> 1 - 2 months <input type="checkbox"/> 3 - 4 months <input type="checkbox"/> 5 - 6 months <input type="checkbox"/> more than 6 months |
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| Please attach a copy of an itemized bill that includes the date, CPT codes and charges for surgery. List surgery date: ____ / ____ / ____ Procedure code: _____ List surgery date: ____ / ____ / ____ Procedure code: _____ <i>Please attach a separate sheet if there were additional surgeries.</i> | Does patient have permanent restrictions and/or limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No Limitations (patient CANNOT DO): Restrictions (patient SHOULD NOT DO): |
|--|--|

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

| | | |
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| Date(s) of office visit (last 6 months): | How often do you see the patient? | Have you referred patient to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date(s) of hospitalization (last 6 months): | | |

| | |
|-----------|-------------|
| Hospital: | Specialist: |
|-----------|-------------|

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|----------|-------|--------|------|----------|-------|--------|------|
| Address: | City: | State: | ZIP: | Address: | City: | State: | ZIP: |
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| Telephone: | Fax: | Telephone: | 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 attending physician portions of the claim form.

| | |
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| _____ | _____ |
| Physician signature | Date (MM/DD/YYYY) |

| | |
|-----------------------|-------------------------|
| Physician/group name: | Patient account number: |
|-----------------------|-------------------------|

| | | |
|------------------------|------------|------|
| Physician's specialty: | Telephone: | Fax: |
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| | | | |
|----------|-------|--------|------|
| Address: | City: | State: | ZIP: |
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| Tax ID or SSN: | Do you accept medical record requests by fax? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|----------------|--|

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| Was patient referred to you by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have authorization on file to release information to Colonial Life? <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Do you require a special authorization for release of information? <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient Portal <input type="checkbox"/> Yes <input type="checkbox"/> No | Will you accept the standard HIPAA release? <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Referring physician: | Telephone: | Fax: |
|----------------------|------------|------|

| | | | |
|----------|-------|--------|------|
| Address: | City: | State: | ZIP: |
|----------|-------|--------|------|

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, 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) |
| Printed name of individual subject to this disclosure | XXX-XX-_____ 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) |
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