Critical Illness Claim Filing Instructions

For a Critical Illness claim, have you…

1. Completed the Primary insured's Statement and Claimant's Statement sections along with the Critical Illness Information section in full?
2. Attached a copy of the claimant's birth certificate?
3. Had the claimant's treating physician complete the Physician's Statement and had it returned to you?
4. Attached the pathology report that confirms the diagnosis if you are filing for cancer under the critical illness plan?
5. Read, signed and dated the Authorization for Release of Information?
6. Signed the appropriate Parent/Guardian signature lines for a dependent claim?

For a Wellness Screening claim, have you…

a. Filled out the first 6 lines of the Primary insured's Statement and Claimant's Statement sections as well as the Wellness Screening Information section in full?
b. Attached documentation indicating the type of test performed and the date the test was performed?

For a Return of Premium Death Benefit claim, have you…

1. Filled out the first 6 lines of the Primary insured's Statement and Claimant's Statement sections as well as the Return of Premium Death Benefit Information section in full?
2. Attached a copy of the Death certificate?

Submit the completed statements to the address below or fax to 1-(866) 376-9480.

All portions of these forms must be completed in order to expedite your claim.

If you have any questions when completing this form, please call:

Toll-Free Phone Number 1-(866) 537-7629

Disability RMS
300 Southborough Drive, Suite 200
South Portland, ME 04106-6914

Disability RMS
Claims Department
Fax 1-(866) 376-9480
Phone 1-(866) 537-7629

NOTICE OF CLAIM FOR CRITICAL ILLNESS

PRIMARY INSURED'S STATEMENT (TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

NAME OF PRIMARY INSURED		PRIMARY INSURED'S TELEPHONE NO. ( ) -
PRIMARY INSURED'S ADDRESS STREET & NO. CITY STATE ZIP		
EMPLOYED BY	OCCUPATION	DATE EMPLOYED / /
PRIMARY INSURED'S SOCIAL SECURITY - -	PRIMARY INSURED'S DATE OF BIRTH / /	PRIMARY INSURED'S GENDER ☐ MALE ☐ FEMALE

CLAIMANT'S STATEMENT (TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

NAME OF CLAIMANT		RELATIONSHIP TO THE PRIMARY INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT
CLAIMANT'S GENDER ☐ MALE ☐ FEMALE	CLAIMANT'S DATE OF BIRTH / /	CLAIMANT'S DATE OF DEATH (IF APPLICABLE) / /

CRITICAL ILLNESS INFORMATION

WHAT IS THE SPECIFIC CRITICAL ILLNESS OR PROCEDURE FOR WHICH THE CLAIM IS BEING MADE?

- ☐ Heart Attack
- ☐ Coronary Bypass Surgery
- ☐ Invasive Cancer
- ☐ Coma
- ☐ Major Burns
- ☐ Paralysis, Other Than Stroke
- ☐ Heart Transplant
- ☐ Stroke
- ☐ Angioplasty
- ☐ Cancer In Situ
- ☐ End-Stage Renal Failure
- ☐ Major Organ Transplant

WHEN WAS THE CRITICAL ILLNESS FIRST DIAGNOSED OR PROCEDURE UNDERGONE?

/ /

HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION OR PROCEDURE IN THE PAST? ☐ YES ☐ NO

IF "YES", WHEN?

/ /

LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR YOUR PRIMARY CARE PHYSICIAN

LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL TREATING PHYSICIAN FOR THE CRITICAL ILLNESS

(Please attach a separate sheet of paper if additional space is needed)

IF THE CRITICAL ILLNESS REQUIRED HOSPITALIZATION PROVIDE THE NAME AND ADDRESS FOR THE TREATING FACILITY

WELLNESS SCREENING INFORMATION

- ☐ stress test on a bicycle or treadmill
- ☐ fasting blood glucose test
- ☐ blood test for triglycerides
- ☐ serum cholesterol test to determine level of HDL and LDL
- ☐ bone marrow testing
- ☐ breast ultrasound
- ☐ CA15-3 (blood test for breast cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ CEA (blood test for colon cancer)
- ☐ chest x-ray
- ☐ colonoscopy
- ☐ flexible sigmoidoscopy
- ☐ hemocult stool analysis
- ☐ mammography
- ☐ pap smear
- ☐ PSA (blood test for prostate cancer)
- ☐ serum protein electrophoresis (blood test for myeloma)
- ☐ thermography

DATE THE HEALTH SCREENING WAS PERFORMED

/ /

ATTACH THE INVOICE FOR THE WELLNESS SCREENING PREFORMED AND THE NAME AND COMPLETE ADDRESS OF MEDICAL PROVIDER

RETURN OF PREMIUM DEATH BENEFIT INFORMATION

- ☐ PRIMARY INSURED
- ☐ SPOUSE

*The Return of Premium Death Benefit does not apply to dependent coverage.

CLAIMANT'S DATE OF DEATH
(IF APPLICABLE)

/ /

FRAUD NOTICES

Unless specific state language is provided below, **the following general fraud notice applies:** 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.

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.

Arkansas, Louisiana, New Mexico, 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.

California – For your protection California law requires the following to appear on this form: "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."

Delaware, Florida, Idaho, Indiana, Oklahoma – 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.

District of Columbia, Colorado – WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

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, Alabama, Rhode Island and Texas - 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.

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 files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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 stated value of the claim for each such violation.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND COMPLETE. IF MY ANSWERS ON THIS CLAIM FORM ARE INCORRECT OR UNTRUE, OR IF I REFUSE TO SIGN THE AUTHORIZATION FOR RELEASE OF INFORMATION, UNION SECURITY INSURANCE COMPANY HAS THE RIGHT TO DENY MY CLAIM.

Signature of Primary Insured: _____ Date: _____

Signature of Claimant: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and Union Security Insurance Company *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by Disability RMS, Union Security Insurance Company and the above-described representatives to evaluate and adjudicate my current critical illness claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Disability RMS or Union Security Insurance Company may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent Disability RMS and/or Union Security Insurance Company have relied previously upon this authorization for the use or disclosure of my protected health information. I understand Union Security Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair Disability RMS' and Union Security Insurance Company's ability to evaluate my current critical illness claim and as a result lack of required information may be a basis for denying that current critical illness claim for benefits.

*If you reside in **California:** this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

If you reside in **Connecticut, Maine, or Massachusetts: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

***If you reside in **Vermont:** This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Disability RMS to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Disability RMS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name: _____ Date of Birth: _____

Claimant Signature (or Authorized Representative): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Description of Personal Representative's Authority (if applicable):
(If signed by authorized representative, attach verification of identity)

Disability RMS
Fax 1-(866) 376-9480
Phone 1-(866) 537-7629

ATTENDING PHYSICIAN'S STATEMENT - THIS STATEMENT MUST BE FILLED-IN COMPLETELY BY A PHYSICIAN

(Please Print or Type)

Name of Patient _____ *FIRST* *MIDDLE* *LAST*		Patient's Date of Birth / /
Patient's Relationship to Primary Insured ☐ Self ☐ Spouse ☐ Dependent	Patient's Gender ☐ Male ☐ Female	Date of Death (if applicable) / /

1. HISTORY:

a. When did symptoms of the illness first appear?

Mo._____ Day _____ Year _____

b. Please explain the specific diagnosis and date diagnosed.

_____

c. Date patient first consulted you for this condition: Mo._____ Day _____ Year _____

d. Has patient ever had same or similar condition? ☐ Yes ☐ No

If "Yes", state first treatment dates and describe.

_____

_____

e. Was this patient referred to you? ☐ Yes ☐ No

If "Yes", by whom and what is their specialty?

_____

_____

f. Have you referred this patient to another treating provider? ☐ Yes ☐ No

If "Yes", to whom and what is their specialty?

_____

_____

g. For services related to hospitalization, give the hospitalization dates: Admit: _____ Discharge: _____
Admit: _____ Discharge: _____
Admit: _____ Discharge: _____

h. Name and address of facility where services rendered (if other than home or office).

_____

_____

i. To your knowledge has your patient used tobacco? ☐ Yes ☐ No

If "Yes", amount per day and date last used.

_____

j. Do you know if any family members have suffered from this or a similar disease? ☐ Yes ☐ No

If "Yes", please provide details.

_____

_____

2. DIAGNOSIS/MEDICAL DOCUMENTATION REQUIRED:

Please provide the test results, operative reports, pathology reports, and/or your detailed medical statement for claimed critical illness or procedure below:

Condition	**Medical Documentation**
☐ HEART ATTACK	Any of the following: Electrocardiograph (EKG), Cardiac biomarkers, Thallium scans, MUGA scans, Stress echocardiogram, any applicable reports
☐ STROKE	Documented neurological deficits and/or neuroimaging studies
☐ CORONARY BYPASS SURGERY	Open heart surgical report
☐ ANGIOPLASTY	Attach a copy of the operative report
☐ INVASIVE CANCER	Pathology report
☐ CANCER IN SITU	Pathology report or medical evidence that supports the diagnosis of cancer
☐ COMA	Test results used to determine how deep the coma state was
☐ END-STAGE RENAL FAILURE	Regular hemodialysis and/or peritoneal dialysis
☐ MAJOR BURNS	Documentation of specific location on the body; percentage of the body and degree
☐ MAJOR ORGAN TRANSPLANT	Surgical reports
☐ PARALYSIS, OTHER THAN STROKE	Clinical diagnosis
☐ HEART TRANSPLANT	Surgical reports

a. Diagnosis or nature of illness or injury, relate diagnosis to procedure by reference in Column D to Numbers 1, 2, 3, etc. or DX code.
Note: If possible, please give CPT-4 procedure code in the “C” below and ICD in “D”

1.

2.

3.

4.

Our contract requires that the covered illness be diagnosed by a Physician who is not related to the insured. Are you related to this patient? ☐ Yes ☐ No

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 act, which is a crime and subjects such person to criminal and civil penalties.

PHYSICIAN’S SIGNATURE _____ DATE _____

PHYSICIAN’S NAME (PLEASE PRINT) _____

DEGREE/SPECIALTY _____

TELEPHONE NUMBER (_____)_____- _____ FAX NUMBER (_____)_____- _____ TAX ID # _____

OFFICE ADDRESS _____
NUMBER/STREET

_____
CITY OR TOWN *STATE* *ZIP CODE*

PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE