The Baltimore Life® COMPANIES

SecureSolutions® from Baltimore Life

Critical Illness Claimant's Statement

Policy Number **Name of Policy / Certificate Holder**

Address **Telephone Number**

Claimant's Name **E-mail Address**

Relationship to Primary Insured

☐ Self ☐ Spouse ☐ Natural Child ☐ Stepchild ☐ Adopted Child ☐ Other Child If other, explain. _____

Date Illness First Diagnosed _____

Diagnosis

☐ Cancer ☐ Heart Attack ☐ Kidney Failure ☐ Stroke ☐ Organ Transplant

POSITIVE DIAGNOSIS MUST BE MADE BY A LEGALLY LICENSED PHYSICIAN. (A PHYSICIAN'S OR SURGEON'S REPORT MUST ACCOMPANY THE FIRST CLAIM ON ANY INSURED AND EACH SUBSEQUENT DIAGNOSIS.)

LIST ALL PHYSICIANS WHO ATTENDED OR PRESCRIBED FOR THE PATIENT WITHIN THE LAST TEN YEARS.

	Name and Address	Dates of Attendance	Disease
1.			
2.			
3.			
4.			

We certify that all of the foregoing statements and answers are true, complete, and correctly recorded. I understand that the furnishing of these forms by the Company does not constitute (i) an admission that there is any insurance coverage in force or benefit due; and (ii) a waiver of any right.

We hereby authorize any insurance company, pre-payment organization, employer, union, trust fund, hospital or physician to release to The Baltimore Life Insurance Company all information with respect to us or any of our dependents, which may have this authorization, we waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

All financial transactions with proceeds of $10,000 or more will be deposited into an interest-bearing account. You can withdraw your funds all at once or as needed with the personalized draftbook provided to you once your transaction is processed. Drafts are written and processed just like checks. They provide immediate access to your funds.

Please sign your name below as you sign a check. If you are receiving a Baltimore Life Retained Asset Account, this signature will be placed on file with your account.

Date	Signature of Policy / Certificate Holder	Signature of Claimant (Parent if minor)

INSTRUCTIONS

Be certain ALL questions are answered and ALL information requested is furnished.

An Attending Physician's Report must be completed by the attending physician or surgeon or have the physician submit his own completed physician statement.

The Baltimore Life Insurance Company
10075 Red Run Boulevard • Owings Mills, Maryland 21117-4871
800.628.5433 • www.baltlife.com

FRAUD WARNINGS

Alaska: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: Warning - 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.

DC: 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.

Delaware: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree.

Idaho: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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.

New Mexico: Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Warning - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

THE BALTIMORE LIFE INSURANCE COMPANY

10075 Red Run Boulevard • Owings Mills, Maryland 21117-4871
(800) 628-5433 • www.baltlife.com

Name of Patient (Print)					Date of Birth	Policy No.
Present Address	No	Street	City	State (or Province)		ZIP Code
Occupation						Social Security # - -

ATTENDING PHYSICIAN'S STATEMENT FOR CRITICAL ILLNESS

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.

Dear Doctor:
In filling out this report, please include sufficient details of history, physical and laboratory findings, clinical course, therapy and response to enable us to make this determination. The patient is responsible for the completion of this form without expense to the Company.

1. HISTORY

(a) When did symptoms first appear? Mo. _____ Day _____ Year _____

(b) Was illness caused by an accident? Yes _____ No _____

(b) Date patient ceased work because of illness. Mo. _____ Day _____ Year _____

(c) Has patient ever had same or similar condition? Yes _____ No _____

(If yes, state when and describe) _____

(d) Names and addresses of other consulting physicians

_____

_____

2. DIAGNOSIS (including any complications)

	PRIMARY	SECONDARY
(a)		
(b)		
(c)		
(d)		

3. SUBJECTIVE SYMPTOMS: _____

_____

4. OBJECTIVE DATA (Including physical findings, laboratory data, EKGs, x-rays, or any other special tests)

(a) _____

(b) _____

(c) _____

(d) _____

5. DATES AND NATURE OF TREATMENT (Including surgery, if any. Please enclose operative report)

(a) Date of first visit..... Mo. _____ Day _____ Year _____

(b) Date of last visit..... Mo. _____ Day _____ Year _____

(c) Frequency..... Weekly ☐ Monthly ☐ Other (Specify) ☐ _____

(d) Date of last examination..... Mo. _____ Day _____ Year _____

_____

_____

_____

6. CANCER (If applicable). Please attach surgical pathology report if one was prepared.

7. HEART ATTACK (If applicable). Please provide details.

8. KIDNEY FAILURE (If applicable). Please provide nature of kidney disease.

	Date(s)	Value(s)
(a) B.U.N.		
(b) Serum Creatinine		

9. STROKE (If applicable)

Describe extent of weakness/paralysis

Describe extent of mental/cognitive impairment

Describe any visual field defect

10. ORGAN TRANSPLANT (If applicable)

Please specify:

11. REMARKS

DATE | NAME (ATTENDING PHYSICIAN) | DEGREE | TELEPHONE

STREET | CITY OR TOWN | STATE | ZIP CODE

SIGNATURE