

Fax to: Claims 1.866.611.9954

From: _____

No# of pages: _____

OR MAIL TO

Attn: Cancer

P.O. BOX 100266

COLUMBIA, SOUTH CAROLINA 29202-3266

Cancer Claim Form



Please be sure to send the following information:

- ✓ A Pathology report, when filing your first Cancer claim
- ✓ A signed and dated authorization,
- ✓ Copies of any related bills – surgeon, medical imaging, radiation/chemotherapy, hospital, etc.

Fax this direction.

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below for optional services. Any other marks used (check mark, x, etc.) will not be considered as authorization and will be processed as blank.

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

_____ sales representative _____ plan administrator

_____ 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 home phone number indicated on this form. Messages will be left with anyone that answers the phone or on my answering machine. To avoid blocked calls, I should program the number 1.800.325.4368 into my 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 and an \$18.00 fee, which is subject to rate increases by carrier and does not include weekend delivery, will be deducted from my claim payment(s). **We are unable to overnight mail to a P.O. Box and you must notify us in writing to discontinue this service.**

If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)

Section 1 TO BE COMPLETED BY POLICY OWNER			
Claimant name	__Male __Female	Birth Date	Claimant Social Security Number
Policy owner Name (First, Last)		Birth Date	Social Security Number
Mailing Address (Street or PO Box)			(Apartment/Unit/Lot number)
(City)	(State)	(Zip)	Home telephone number ()
Policy owner e-mail address			Work telephone number ()
Date Cancer Diagnosed _____ (MM/DD/YYYY)			
Dates unable to work: From _____ (MM/DD/YYYY)		To _____ (MM/DD/YYYY)	
If not employed, list dates of house confinement:		House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.	
From _____ (MM/DD/YYYY)	To _____ (MM/DD/YYYY)		

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.

Arizona Residents : 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 Residents : 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 Residents : 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 and Maryland Residents : 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.

Florida Residents : 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 Residents : 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.

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 Residents : 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 Residents : 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.

Oregon Residents : Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Puerto Rico Residents : 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.

- ✓ Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them. This is called an assignment. If you wish to assign your benefits, please send a signed written request.
- ✓ 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.

CERTIFICATION

Policy owner's Name _____ Social Security # _____

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 2 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.**

Please remember to also sign and date the attached authorization required to process your claim.

X _____ X _____ X _____
 Claimant's Signature Policy owner's Signature Date (MM/DD/YYYY)

Have you been unable to perform any activities of daily living? ___ Yes ___ No
 If yes, please list the dates you were unable to perform the activities: From _____ To _____
 (MM/DD/YYYY) (MM/DD/YYYY)

Check the activities that you are unable to perform:
 ___ dressing ___ eating ___ meal preparation ___ toileting ___ continence ___ bathing ___ transferring

Date returned to work: Full-time _____ Part-time _____/Hours worked per week _____
 (MM/DD/YYYY) (MM/DD/YYYY)

List all doctors who have treated you for this condition and include your primary doctor's name first.

Doctor's name	Phone Number	Address
1.		
2.		
3.		
4.		

Were you hospital confined? ___ Yes ___ No
 Admitted _____ Discharged _____
 (MM/DD/YYYY) (MM/DD/YYYY)

Hospital name/address/phone number _____



Fax this direction.

Claimant Name _____	Social Security Number _____
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SECTION 2 TO BE COMPLETED BY EMPLOYER (if applicable)

Employee name _____	Date last worked _____ (MM/DD/YYYY)
Hire date _____ SSN _____	Dates employee unable to work (Full-time)
Average number of scheduled hours per week _____	From _____ AM/PM To _____ AM/PM (MM/DD/YYYY) (MM/DD/YYYY)

Date returned to work: Full-time _____ (MM/DD/YYYY)	Part-time _____/Hours per week _____ (MM/DD/YYYY)	Expected return to work _____ (MM/DD/YYYY)
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Employee's job title: _____

Employee's duties include: _____

Lifting	<input type="checkbox"/>	Less than 15 lbs.	<input type="checkbox"/>	15 to 44 lbs.	<input type="checkbox"/>	over 45 lbs.
Stooping/bending	<input type="checkbox"/>	none	<input type="checkbox"/>	seldom	<input type="checkbox"/>	frequent
Crawling/kneeling	<input type="checkbox"/>	none	<input type="checkbox"/>	seldom	<input type="checkbox"/>	frequent
Reaching/pulling/pushing	<input type="checkbox"/>	none	<input type="checkbox"/>	seldom	<input type="checkbox"/>	frequent
Repetitive motion	<input type="checkbox"/>	none	<input type="checkbox"/>	seldom	<input type="checkbox"/>	frequent
Management Duties	<input type="checkbox"/>	none	<input type="checkbox"/>	seldom	<input type="checkbox"/>	frequent

Sitting (number of hours each day): _____ Standing (number of hours each day) _____

Walking (number of hours each day): _____ Climbing Stairs/Ladders (number of hours each day) _____

Who should we contact for updates on return to work status? Name/Phone/Email _____

FRAUD NOTICE: 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.

Signed by _____	Title _____
Print name _____	Date _____ (MM/DD/YYYY)
Telephone Number() _____	Fax Number() _____
Email Address _____	

SECTION 3 TO BE COMPLETED BY PHYSICIAN

Patient's name		Patient's DOB	
What primary condition prevents the patient from working?			
Symptoms:		Objective Findings:	
Date first treated for this condition _____ (MM/DD/YYYY)			
Are any secondary conditions preventing the patient from working? ___Yes ___No		If yes, what are these secondary conditions?	
When did symptoms first appear? _____ (MM/DD/YYYY)	Date of new patient consultation _____ (MM/DD/YYYY)	Date of patient's last visit. _____ (MM/DD/YYYY)	
List any test(s) performed and submit a copy of the results.		List any surgeries performed with the date and procedure code.(CPT) (Attach a copy of the operative report)	
Restrictions (What the patient SHOULD NOT DO)			
Limitations (What the patient CANNOT DO)			
How soon do you expect significant improvement in the patient's medical condition? ___ 1-2 months ___ 3-4 months ___ 5-6 months ___ more than 6 months			Expected return to work _____ (MM/DD/YYYY)
Dates unable to work (full-time): From: _____ To: _____ (MM/DD/YYYY) (MM/DD/YYYY)	Dates unable to work (part-time): From: _____ To: _____ (MM/DD/YYYY) (MM/DD/YYYY)	Actual date released to return to work _____ (MM/DD/YYYY)	
Does this patient have permanent restrictions/limitations? ___Yes ___No	If not employed, list dates of house confinement: From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)	House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.	
Please check the activities of daily living that the patient is unable to perform: __dressing __eating __meal preparation __toileting __continence __bathing __transferring			
Date(s) of office visit (Last 3 Months)		How often do you see the patient?	
Have you referred patient for other types of consultations? ___Yes ___No		Name and address of Specialist	
Dates of Hospitalization (Last 3 months)		Name and Address of Hospital	
FRAUD NOTICE: 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.			
Signature of Physician		Date _____ (MM/DD/YYYY)	Physician's Specialty
Telephone number ()	Fax Number ()	Tax ID or SSN	
Physician/Group Name		Patient Account Number	
Mailing Address		Do you accept Medical Records request by Fax? ___Yes ___No	
Was patient referred to you by another physician? ___Yes ___No		Do you have authorization on file to release information to Colonial Life? ___Yes ___No	
Provide the following information for referring doctor. Name:		Phone number	
Address		Fax number	

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 appropriate 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. Some information 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 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 and access to this information. 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 benefits. 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.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

X _____ XXX-XX-_____
(Signature) (Social Security Number — last 4 digits) (Date of Birth)

(Printed name of individual subject to this disclosure) (Date Signed)

If applicable, I signed on behalf of the insured as _____ (indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed name of legal representative) (Signature of legal representative) (Date Signed)