# Critical Illness Claim Statement

ASSURANT Employee Benefits®

**For your protection, the following disclosures are required by state law and are based on the state where you live:**

**If you live in the states of Alaska or Oregon, the following statement applies to you:**
A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**If you live in the states of Arizona or New Jersey, the following statement applies to you:**
A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**If you live in the states of Arkansas, Louisiana, Maryland, or Rhode Island the following statement applies to you:**
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.

**If you live in the state of California, the following statement applies to you:**
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.

**If you live in Colorado, the following statement applies to you:**
**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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.**

**If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you:** WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

**If you live in the District of Columbia, Tennessee or Virginia the following statement applies to you:**
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.

**If you live in New Hampshire, the following statement applies to you:**
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.



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**If you live in New York the following statement applies to you:**

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 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.

**If you live in Minnesota, the following statement applies to you:**

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

**If you live in Texas, the following statement applies to you:**

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.

**If you live in a state other than mentioned above, the following statement applies to you:**

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.

***To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.***

**Insured Employee Instructions for filing a Critical Illness Claim**

1. Complete Part 1 and Part 4.
2. Complete Part 2 or Part 3 if filing for a dependent.
3. Have the physician complete Part 5.
4. Sign and date the Authorization Sections.
5. Provide Documentation:

Attach medical documentation to support your claim for Critical Illness benefits. Some of the documentation can be obtained by requesting a copy of the medical records, hospital records, hospital bill (UB04) or HCFA1500 (non-hospital bill) from your healthcare provider. See Part 5 for detail of initial medical records to submit.

**Wellness Screening Benefit:** See policy for covered tests or procedures. If submitting a claim for this benefit use the **Wellness Claim Statement (Form KC4916).**

## HIPAA Authorization For Release of Protected Health Information

ASSURANT Employee Benefits®

Insured/Member name _____ SSN _____ DOB _____

Claimant name _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

**Persons/categories of persons providing the information:** Any provider of medical services, insurance or reinsurance company or their authorized representatives, pharmacy, pharmacy benefits manager, or any pharmacy-related service entity, Social Security Administration, governmental agency, consumer reporting agency, vocational provider or employer having medical information, with respect to any physical or mental condition of mine, or non-medical information about me.

**Persons/categories of persons receiving the information**: Union Security Insurance Company or Union Security Life Insurance Company, and their authorized representatives ("Companies").

I hereby authorize the use or disclosure of my protected health information as described below:

**Information to be disclosed:** All information necessary to allow the Companies to determine my eligibility for benefits and to process my claim. Such information may include, but not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes (excluding psychotherapy notes), pharmacy records, strength/functional testing, records regarding my Social Security FICA earnings history, Worker's Compensation, State Disability, credit, and earnings and employment history.

**The sole purpose of this disclosure is for the adjudication of my claim for insurance benefits under the above-referenced Policy.**

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only - we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be disclosed to or used by the insured member under the above policy.
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until my claim ends.

_____ _____

SIGNATURE OF CLAIMANT OR LEGAL REPRESENTATIVE | DATE

_____ _____

PRINTED NAME OF LEGAL CLAIMANT REPRESENTATIVE | RELATIONSHIP TO INSURED/MEMBER

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION***

## Critical Illness Claim Statement

ASSURANT Employee Benefits®

**Part 1 – To be completed by Insured Employee** *(Please print or type.)*

| Full name *(As it appears on your Social Security card.)* | Policy number |
|---|---|
| Employer name | Employer phone number |
| This claim is being filed for: ☐ Self ☐ Spouse ☐ Dependent<br>Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow | Sex: ☐ Male ☐ Female |

| Date of birth | Social Security number | Home phone number |
|---|---|---|

| Street address | City | State | Zip |
|---|---|---|---|

| Mobile phone number | E-mail address |
|---|---|

Did injury result from employment? ☐ Yes ☐ No ☐ Currently disputed

**Part 2 – To be completed by spouse if benefits are for spouse** *(Please print or type.)*

| Full name *(As it appears on your Social Security card.)* | Sex: ☐ Male ☐ Female |
|---|---|

| Date of birth | Social Security number | Mobile phone number |
|---|---|---|

Did injury result from employment? ☐ Yes ☐ No ☐ Currently disputed

**Part 3 – Complete for dependent if benefits are for dependent** *(Please print or type.)*

| Full name (As it appears on your Social Security card.) | Sex: ☐ Male ☐ Female |
|---|---|

| Date of birth | Married? ☐ Yes ☐ No | Social Security number | Mobile phone number |
|---|---|---|---|

Did the illness or injury result from employment? ☐ Yes ☐ No ☐ Currently disputed

**If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority and sign below.**

Signature _____ Relationship to claimant _____

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a critical illness benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Claimant's signature _____ Date _____

**Part 4 – Claim Information***(Please print or type. If necessary, attach separate sheet.)*

This ☐ Initial ☐ Recurrent claim is for

| Primary physician name | Phone |
|---|---|
| Primary physician address | |
| Hospital name | Phone |
| Hospital address | |
| Date which the Critical Illness first diagnosed or procedure undergone | |

**Benefits payable are determined by the policy. All conditions listed may not be in your particular policy. See policy for details.**

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

**Part 5 – Physician's Statement -** *This statement must be filled in completely by a physician. (Please print or type.)*

| Condition | Medical Documentation Needed<br>Additional medical information may be requested |
|---|---|
| ☐ Benign Brain Tumor | Hospital discharge summary, pathology report, and current assessment to address any persistent neurological deficits. |
| ☐ Blindness | Ophthalmologist's report with visual acuity and visual fields at onset and six months post onset |
| ☐ Coma | Hospital records and test results at onset and one week post event |
| ☐ Complete loss of hearing | Audiogram testing results with documented decibel hearing loss. |
| ☐ End-stage Kidney Disease | Physician or dialysis center report of regular hemodialysis and/or peritoneal dialysis for longer than 90 days and chronic and irreversible kidney failure |
| ☐ Loss of Speech | Speech evaluations at onset date and six months post onset date. |
| ☐ Major Organ Failure | Proof of listing with United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP) |
| ☐ Paralysis | Initial hospital discharge summary and assessment at 6 months post onset |
| ☐ Occupational Infectious Diseases | • Documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation;<br>• A negative antibody for HIV (or Hepatitis B, C and/or D) test, performed by a state certified and licensed laboratory within five days of exposure; and<br>• A positive antibody for HIV (or Hepatitis B, C and/or D) test, taken in the 90 to 180 days following the exposure. |
| ☐ Stroke | Neuroimaging studies, hospital discharge summary, and current assessment |

| Condition | Medical Documentation Needed<br>Additional medical information may be requested |
|---|---|
| **ALS/Alzheimer's/Parkinson's** | |
| ☐ Advanced ALS/Lou Gehrig's Disease* | Documentation of diagnosis by a physician. Requires either a feeding tube or non-invasive ventilation. |
| ☐ Advanced Alzheimer's Disease* | Documentation of diagnosis on the FAST Staging Scale (Stage 6 or higher) related to Alzheimer's related dementia by a qualified medical provider. Current assessment documenting neurological impairments. |
| ☐ Advanced Parkinson's Disease* | Documentation of primary idiopathic Parkinson's disease at stage 4 or higher on the Hodhn/Yahr scale by a qualified neurologist. Neurologist evaluation addressing current physical examination/condition. |
| *Also requires that the claimant is unable to perform 3 or more of the following activities of daily living: bathing, dressing, toileting, transferring, continence or eating. See policy for details. | |
| **Heart** | |
| ☐ Angioplasty | Surgical report and hospital discharge summary |
| ☐ Coronary Bypass Surgery | Surgical report and hospital discharge summary |
| ☐ Heart Attack | Cardiac enzyme and biomarkers, Electrocardiogram (EKG), Thallium scans, MUGA scans, Stress echocardiogram, hospital discharge summary, and cardiac catheterizations |
| ☐ Heart Failure | Proof of listing with United Network of Organ Sharing (UNOS) |
| **Cancer** | |
| ☐ Cancer in situ | Pathology report |
| ☐ Invasive Cancer | Pathology report, operative report (if available), and laboratory records |
| ☐ Skin Cancer | Pathology report documenting evidence of basal cell or squamous cell cancer of the skin. |
| **Child-Specific Critical Illnesses** | |
| ☐ Cerebral Palsy | Medical assessment by a physician confirming the diagnosis of cerebral palsy and documentation of developmental delays, physical findings, posture abnormalities, and any intellectual or behavioral difficulties. |
| ☐ Cleft Lip/Palate | Current assessment from a physician documenting the cleft lip or cleft palate by routine examination. |
| ☐ Cystic Fibrosis | Sweat chloride test and genetic testing confirming cystic fibrosis. |
| ☐ Down Syndrome | Genetic testing (chromosome study) which confirms the diagnosis of Down Syndrome. |
| ☐ Muscular Dystrophy | Diagnosis of either Duchenne or Becker muscular dystrophy with confirmation by CPK blood test, muscle biopsy, electromyography and genetic testing. |
| ☐ Spina Bifida | Current assessment documenting the diagnosis of spina bifida either by diagnostic testing (x-ray, MRI, CT) or by routine examination. |
| ☐ Type I Diabetes | Fasting blood glucose testing, oral glucose tolerance testing, hemoglobin A1C lab testing. Current assessment from the treating physician describing diagnosis and lab results. Must be on insulin therapy. |

| Date symptoms first appeared | Date of diagnosis | ICD-9 code |
|---|---|---|
| | | |

Are any of the following a contributing factor in the condition? *(Check all that apply.)*

☐ Use of drugs ☐ Committing a Felony ☐ Intoxication ☐ Self-inflicted ☐ Attempted Suicide

Has this patient been treated for this same or similar condition prior to this occurrence? ☐ Yes ☐ No
If "Yes," please provide diagnosis, the dates of treatment and names of other medical providers.

Provide the name, address and phone number of any referring physicians.

**For services related to a hospitalization, please provide the following.** *(Please print or type.)*

Name of hospital

| Street address of hospital | City | State | Zip | Phone |
|---|---|---|---|---|
| | | | | |

| Admission date | Discharge date |
|---|---|
| | |

**Physician's Information** *(Please print or type.)*

| Name | Degree | Specialty/Board Certification |
|---|---|---|
| | | |

| Street address | City | State | Zip |
|---|---|---|---|
| | | | |

| Phone | Fax |
|---|---|
| | |

| Physician's signature | Date |
|---|---|
| | |

DO NOT PRE-DATE