

CRITICAL ILLNESS CLAIM FORM



CHECK LIST

Item 1 – Insured's Statement of Claim

- ☐ Must be completed each time you file a claim.
- ☐ Be sure to answer every question.

Item 2 – Authorization

- ☐ Claimant or Authorized Representative must sign and date Authorization on Page 2 to allow physicians to release medical records to Companion Life.

Item 3 – Prior Treatment Form

- ☐ If the provider's fax numbers are known, please provide them in order to expedite this process.
- ☐ Please make certain authorization on page 2 is signed and dated.

Item 4 – Physicians Statement

- ☐ To be completed by medical provider.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECESSARY DELAY IN THE PROCESSING OF YOUR REQUESTS FOR BENEFITS.

Return the fully completed claim form and supporting documentation by any of the methods below:



Phone: 866-473-6615

Fax: 610-374-6986

Mail: P.O. Box 13668, Reading, PA 19612-3668

Submit Claim Via Online Portal: <https://flexbenefits.loomislive.com/view/login>



Administered by The Loomis Company
P.O. Box 13668
Reading, PA 19612-3668

CRITICAL ILLNESS CLAIM FORM

INSURED'S STATEMENT OF CLAIM		TO BE COMPLETED BY POLICYHOLDER	
Name of Insured	Social Security Number		Policy & Certificate Number
Street Address	City	State	ZIP Code
Phone Number (Area Code First)	Email Address		Insured's Date of Birth
Name of Claimant	Relationship to Insured	Claimant's Date of Birth	Gender ☐ Male ☐ Female
Type of Critical Illness for which claim is being made ☐ Heart Attack ☐ Stroke ☐ Major Organ Transplant ☐ Coronary Artery Bypass ☐ Invasive Cancer (Diagnosis after the first 30 days of in force coverage through 90 days of in force coverage) ☐ Invasive Cancer (Diagnosis more than 90 days after effective date of coverage) ☐ Cancer In Situ (Diagnosis after the first 30 days of in force coverage through 90 days of in force coverage) ☐ Cancer In Situ (Diagnosis more than 90 days after effective date of coverage)			Date that Critical Illness was first diagnosed
Describe the onset, length of confinement, any surgical procedures or diagnoses related to the nature of your illness.			
Date you were first treated for your illness or injury: Date: _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address		
Have you ever had the same or similar condition in the past? ____ Yes ____ No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address		
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULANT 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. THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. Signature of Insured: _____ Date: _____			

AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.
2. I authorize all health care professionals to disclose my protected health information.
3. I authorize only designated staff of Companion Life or its contracted third-party administrators to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
5. I understand that my providers may not refuse to provide treatment for health care services if I refuse to sign the Authorization.
6. I further understand that if I refuse to sign this Authorization to release my complete medical record, Companion Life Insurance Company may not be able to make any benefit payments.
7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Companion Life. This revocation shall become effective on the date it is received by Companion Life. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.
8. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

Signature

Print Name

Date

I have legal authority* under the laws of the State of _____ to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

Name of Authorized Representative, Parent or Guardian

Relationship to Applicant

Date

* A copy of the legal authority document must be on file with Companion Life.

PRIOR TREATMENT FORM

Please complete the following and sign and date the authorization on the preceding page.

Please list all physicians who treated the patient in the last year:

Physician's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Approximate Date Consulted: _____ Diagnosis: _____

Physician's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Approximate Date Consulted: _____ Diagnosis: _____

Physician's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Approximate Date Consulted: _____ Diagnosis: _____

Physician's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Approximate Date Consulted: _____ Diagnosis: _____

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 subject to prosecution and punishment for insurance fraud.

PHYSICIAN'S STATEMENT

Claimant Name: _____ Policy/Certificate #: _____

To Be Completed By the Medical Provider.

1. Provide the diagnosis(es), the date of diagnosis and the ICD-9/ICD-10 code(s) for the conditions for which you are treating this patient.

Diagnosis	ICD-9/ICD-10 Code	Date of Diagnosis

2. Has this patient been treated for this same or similar condition in the past prior to this occurrence?

Yes _____ No _____

If yes, please provide diagnosis, the dates of treatment and referring physician(s).

3. Please provide the name and address of any referring physician(s) for this occurrence.

PHYSICIAN'S STATEMENT – CONTINUED

Claimant Name: _____ Policy/Certificate #: _____

*****PLEASE READ CAREFULLY*****

PLEASE ATTACH ALL MEDICAL RECORDS PERTAINING TO THIS DIAGNOSIS AND TREATMENT, INCLUDING LABORATORY DATA AND RESULTS OF DIAGNOSTIC TESTS, CONFIRMING THE DIAGNOSIS AND SEVERITY OF THE CONDITION, OFFICE VISIT NOTES, SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THE PAST TWO YEARS. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS. A LIST OF REQUIRED DOCUMENTS CAN BE FOUND BELOW; THIS LIST IS NOT ALL INCLUSIVE AND ADDITIONAL DOCUMENTS MAY BE REQUESTED.

Illness (not all illnesses are applicable to all policies)	Medical Documentation Needed
Heart Attack	Diagnosis based on the following: new EKG changes consistent with and supporting the diagnosis of heart attack; elevation of cardiac enzymes above generally accepted laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used); imaging studies such as thallium scans, MUGA scans or stress echocardiograms.
Stroke	Documented neurological impairment or deficits; evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test); permanent neurological deficit measured three months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.
Major Organ Transplant	Medical records that demonstrate major organ failure; and proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human-to-human replacement of the failing organ.
Coronary Artery Bypass Surgery	Operative report document major surgery requiring median sternotomy (division of breastbone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of cardiologist; results on angiography testing that diagnosed coronary heart disease.
Invasive Cancer (Diagnosis after the first 30 days of in force coverage through 90 days of in force coverage)	Diagnosis based on pathologist's report or, in the event that the carcinoma in situ was diagnosed without surgery, laboratory and X-ray examination reports used to make the definitive diagnosis of cancer.
Invasive Cancer (Diagnosis more than 90 days after effective date of coverage)	Diagnosis based on pathologist's report or, in the event that the carcinoma in situ was diagnosed without surgery, laboratory and X-ray examination reports used to make the definitive diagnosis of cancer.
Cancer in Situ (Diagnosis after the first 30 days of in force coverage through 90 days of in force coverage)	Diagnosis based on pathologist's report or, in the event that the carcinoma in situ was diagnosed without surgery, laboratory and X-ray examination reports used to make the definitive diagnosis of carcinoma in situ.
Cancer in Situ (Diagnosis more than 90 days after effective date of coverage)	Diagnosis based on pathologist's report or, in the event that the carcinoma in situ was diagnosed without surgery, laboratory and X-ray examination reports used to make the definitive diagnosis of carcinoma in situ.

Medical Provider's Name (Please Print) _____ Phone Number _____ Fax Number _____

Medical Provider's Signature _____ Tax ID Number _____ Date _____

CLAIM FORM FRAUD WARNINGS

GENERAL FRAUD 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 FINES AND CONFINEMENT IN PRISON. The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents 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.

Alaska: 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.

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: 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: 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.

Delaware: 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: 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: 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.

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 commits a felony.

Kansas: Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a criminal act punishable under law and may be subject to civil penalties.

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.

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

Massachusetts: 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 or contract for insurance may be found 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 R.S.A. 638:20.

New Mexico: 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 an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.

Rhode Island: 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.

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.

Texas: 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.

Vermont: 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 may be guilty of fraud and may be subject to criminal or civil penalties.

Virginia: 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.

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 include imprisonment, fines, and denial of insurance benefits.



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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.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ááh naa'nílígi háá'ída yí na' ídít kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'ishíí bí na'ídołkidígi doo bik'é'azláagóo. Ata' halne'é la' bich'í' ha desdizih nínízingo, koji' béesh bee hólne' 1-844-516-6328. (Navajo)



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Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)
