Colonial Penn Life Insurance Company
Home Office: PO BOX 1918 Carmel IN 46082-1918

Questions about your claim submission?
CALL (800) 523-9100

CANCER – CRITICAL ILLNESS ACCELERATED DEATH CLAIM FORM

We want to make the process of filing a claim as fast and simple as possible. We need specific information to process a claim:

- ✓ Patient Information
- ✓ Completed Licensed Physician's statement (see attached form)
- ✓ Authorization to obtain medical/confidential information (see attached form)
- ✓ Positive pathology report that diagnosed cancer
- ✓ Supporting medical records

WHERE TO SUBMIT CLAIMS:

Mail: Colonial Penn Life Insurance Company P.O. Box 1918 Carmel, IN 46082-1918 **Fax:** 215-928-6052	**Express mail**: Colonial Penn Life Insurance Company Attn: Claim Processing 1918 11825 N. Pennsylvania St Carmel IN 46032

SECTION A: OWNER INFORMATION (please print)		
Policy number		
Last name	First name	Middle initial
Date of birth	Social Security number	
Mailing address ☐ Check box if this is a new permanent address		
City	State	ZIP code
If mailing address is a P.O. Box, please indicate physical address here:		
E-mail		
Primary phone number	May we leave a voice mail here? ☐ Yes ☐ No	

SECTION B: INSURED INFORMATION (if different from Owner)		
Last name	First name	Middle initial
Social Security number	Date of birth	Phone number
Mailing address		
City	State	ZIP code

SECTION C: MEDICAL AND PROVIDER INFORMATION			
Has the patient been diagnosed with Cancer? ☐ Yes ☐ No If yes, please provide diagnosis information below:			
Cancer type	Date of diagnosis	Physician name	Physician address
Please provide the names, addresses and phone numbers of all physicians who have treated the patient or with whom they have consulted in the last five years **(please list additional providers on a separate sheet of paper)**:			
Provider name	Phone number	Fax number	

Address		
Provider name	Phone number	Fax number
Address		
Provider name	Phone number	Fax number
Address		
Provider name	Phone number	Fax number
Address		

Please be sure to include the following with this claim form as applicable:

☐ **Positive pathology report that diagnosed cancer**

☐ **Supporting medical records**

☐ **Itemized bills from a physician and/or facility including diagnosis**

(Itemized bills may include but are not limited to the following claim forms: UB04, CMS 1500)

By signing my name on this document, I declare that all information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of signing this form. *

_____ _____ ___/_____/_____

Signature of Insured (or legal representative) Relationship to owner Date

I understand that payment to the Owner based on this form may substantially reduce the death benefit of which I am the beneficiary and that payment is subject to my final approval.

_____ _____/_____/_____

Signature of Beneficiary (if Irrevocable)/Assignee Date

In order to qualify for this benefit, I understand that the Insured must be diagnosed with cancer. This being the case, I hereby request the amount shown in the policy under the Accelerated Death Benefit Provision of the policy. I further understand that payment will be made in accordance with the policy language.

_____ _____/_____/_____

Signature of Owner (or legal representative) Date

***Receipt of accelerated death benefits may be taxable. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.**

SECTION D: LICENSED PHYSICIAN STATEMENT **Must be completed and signed by the licensed physician** (as defined in Section 1861(r)(1) of the Social Security Act.)		
Patient name	Patient date of birth	
LICENSED PHYSICIAN INFORMATION		
Name	Phone number	Fax number
Mailing address		
City	State	ZIP code
Are you related to the patient or have a financial interest in the payment of a benefit to the patient? ☐ Yes ☐ No If yes, please explain:		
CANCER – CRITICAL ILLNESS CERTIFICATION		
Has the patient been diagnosed with Cancer? ☐ Yes ☐ No		
If yes, please provide type and ICD Code **(please provide pathology report)**		
Date of diagnosis	Physician's name	Physician's address
Date of first treatment	Physician's name	Physician's address

_____ ____/____/_____ _____

Licensed Physician's printed name Date Tax ID Number

_____

Licensed Physician's signature

FRAUD WARNING NOTICES
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

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, DELAWARE, FLORIDA, IDAHO, NEW YORK: Your state requires us to notify you that: 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 as further defined by your state statute.

ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, 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.

ARIZONA, KENTUCKY, OHIO: WARNING: 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.

CALIFORNIA: For your protection California law requires the following warning statement 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.

COLORADO: WARNING: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

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.

INDIANA, MINNESOTA: Your state requires us to notify you that: any 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.

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.

NEW HAMPSHIRE: Your state requires us to notify you that any person, 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 under New Hampshire law.

NEW JERSEY, PENNSYLVANIA: NOTICE: 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.

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.

PUERTO RICO: 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 dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] 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.

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.

Authorization to obtain medical/confidential information

Conforms to HIPAA Privacy Rule

1. My information—the individual who is the subject of the information

Printed name	Date of birth	Social Security number

Address	City	State	Zip

2. Disclosing party—parties authorized to release information about me

Any physician or other healthcare provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency or my employer

3. Description of my information authorized for release

- Any information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse; and
- Any information regarding my past, present or future employment that is reasonably necessary to process and administer my claim(s) for accident insurance and/or disability income insurance benefits.

4. Purpose of authorization—how my information will be used

To administer benefits under a policy or certificate of insurance.

5. Duration of authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: _____

6. Receiving parties—parties authorized to receive information about me

CNO Services, LLC on behalf of one or more of the following insurance companies: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company*, Colonial Penn Life Insurance Company, Conseco Life Insurance Company of Texas, Washington National Insurance Company, Primerica Life Insurance Company, Jefferson National Life Insurance Company

*domiciled in and licensed in the State of New York

7. Important information—review carefully before signing

- Refusing to sign this authorization does not affect my ability to obtain medical treatment but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
- This authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: Customer Service P.O. Box 1918, Carmel, IN 46082-1918.
- The receiving parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I have a right to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.
- California residents are entitled to a large print version of this form by calling (800) 523-9100 to request form HEALTHMEDAUTH-LARGE.

8. Approval—must be signed and dated by me or my legal representative* to be valid

Print name: _____ Relationship:_____

Signature: _____ Date: _____

* Legal representatives provide documentation of legal authority

Claims Department, P.O. Box 1918, Carmel, IN 46082-1918
Phone: (800) 523-9100