

CONTINENTAL AMERICAN INSURANCE COMPANY

Post Office Box 84075 * Columbus, GA. 31993-9103

Phone (800) 433-3036 * Fax (866) 849-2970

**CRITICAL ILLNESS CLAIM FORM****Please review your policy for specific benefits covered under your plan**

- ✓ To prevent processing delays, please have claim form completed in full and return the signed HIPAA
- ✓ Please submit medical documentation from your healthcare provider to support your claim

POLICYHOLDER/ CLAIMANT INFORMATION

Employer's Name:	Policy/Certificate No.	Social Security No.	Date of Birth	Gender:
Policyholder's Name:				
Policyholder's Address: (Full Street Address in addition to city, state, zip)		Policyholder's E-Mail:	Telephone Number:	
<input type="checkbox"/> Check Box If This Is A Permanent Address Change				
Patient's name:	Relationship To The Policyholder:	Date of Birth:	Gender:	

By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you).

PLEASE INDICATE THE CONDITION FOR WHICH THE PATIENT IS FILING:

- ☐ **Cancer; Carcinoma in situ; Skin Cancer:** Please submit a copy of the pathology report from which the condition was diagnosed.
- ☐ **Heart Attack; Sudden Cardiac Arrest:** Please submit a copy of the discharge summary, cardiology consult report, cardiac catheterization report, history & physical, and ER notes.
- ☐ **Coronary Artery Bypass Surgery:** Please submit a copy of the operative report for the procedure.
- ☐ **Major Organ Transplant; Bone Marrow Transplant:** Please submit a copy of the operative report for the procedure.
- ☐ **Stroke:** Please submit a copy of the discharge summary, MRI and/or CT test reports from the initial diagnosis, as well as proof of permanent neurological damage (i.e. follow up CT and/or MRI reports, office notes from neurologist or therapist, etc.)
- ☐ **Renal Failure:** Please submit proof of the start date for dialysis or the operative report for transplant. The End Stage Renal Disease Medical Evidence Report is preferred.
- ☐ **Heart Event:** Please submit a copy of the operative report for the procedure.
- ☐ **Loss of Sight, speech, hearing, coma, burns, paralysis:** Please submit medical documentation from the health care provider indicating the diagnosis and severity

Disclaimer: Some of the conditions and services listed may not be covered by your policy**TRANSPORTATION AND LODGING**

DATE	TO/ FROM	ROUND-TRIP MILEAGE

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

Any person, who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime

I hereby certify that the answers I have provided to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

POLICYHOLDER'S SIGNATURE: _____

DATE: _____

PATIENT'S SIGNATURE: _____

DATE : _____



CRITICAL ILLNESS CLAIM FORM

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ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME:		DATE OF BIRTH:
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? <input type="checkbox"/> YES, WHEN _____. <input type="checkbox"/> NO	DIAGNOSIS (INCLUDING COMPLICATIONS)

CANCER/ CARCINOMA IN SITU

DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED)	WAS THE CANCER/CARCINOMA IN SITU <input type="checkbox"/> DIAGNOSED PATHOLOGICALLY <input type="checkbox"/> CLINICALLY DIAGNOSED
IF THE CANCER/CARCINOMA IN SITU WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA IN SITU WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.	

MYOCARDIAL INFARCTION (HEART ATTACK)

DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

- | | | |
|---|-----|----|
| 1. ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKGs AND REPORTS. | YES | NO |
| 2. WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHOSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT. | YES | NO |
| 3. DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS. | YES | NO |
| 4. DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION? | YES | NO |

DATE OF DIAGNOSIS: (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)

CORONARY ARTERY BYPASS SURGERY

DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT CONDITION CAUSED THE NEED FOR CORONARY ARTERY BYPASS SURGERY?	DATE THE PATIENT WAS FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?	

MAJOR ORGAN TRANSPLANT

DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, LIVER, LUNG, KIDNEY, PANCREAS, OR BONE MARROW? IF SO, ATTACH COPY OF THE OPERATIVE REPORT.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	DATE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?	

STROKE

DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTEBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA FOLLOWING THE DIAGNOSIS? PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN) REPORT, MAGNETIC RESONANCE IMAGING (MRI) REPORT, OFFICE NOTES, OR PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY NOTES.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?)		

RENAL FAILURE

DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS)		
WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE?	DATE THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?	



CRITICAL ILLNESS CLAIM FORM

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ATTENDING PHYSICIAN'S STATEMENT (continued)			
PATIENT NAME:		DATE OF BIRTH:	
5.	Is the patient unable to perform job duties? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide dates:		
What specific job duties is patient unable to perform?			
Restrictions and Limitations: (Please quantify in hours, weight, etc.)			
6.	If retired or unemployed which activities of daily living (ADLs) is patient unable to perform?		
7.	Is the patient: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed Confined <input type="checkbox"/> House Confined <input type="checkbox"/> Other	Was the patient hospitalized or confined to a skilled nursing facility? Hospital : Address:	
Date Admitted:		Date Discharged:	
8.	Date you expect patient to resume <u>partial duties</u> ?		Date you expect patient to resume <u>full duties</u> ?
9.	If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities?		
10.	Was the patient treated by any other physician's for this condition? <input type="checkbox"/> NO <input type="checkbox"/> YES <u>Please provide names and addresses of other treating physicians:</u>		
<p><i>Remember, it is unlawful to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to page 3 for notice specific to your state</i></p> <p><i>I hereby certify that the above described information is based upon reasonable medical probability and is true and correct to the best of my knowledge and belief.</i></p>			
ATTENDING PHYSICIAN'S SIGNATURE			
I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.			
Name (Attending Physician) Please Print:		Degree:	
Address:		Telephone Number:	
City:		State:	Zip code:
Signature:		Medical Id#:	

FRAUD WARNING NOTICES
For use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

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.

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.

California: For your protection California 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: 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 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.

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

FRAUD WARNING NOTICES
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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: 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.

New York: 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.

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.

Oregon: 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 may be guilty of insurance fraud.

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.

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 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.

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.

<p style="text-align: center;">FRAUD WARNING NOTICES For use with Claim Forms PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE</p>
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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.

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.

ALL OTHER STATES: 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.