Monumental Life Insurance Company

# Insurance Claim Filing Instructions

## PROOF OF LOSS CONSISTS OF THE FOLLOWING:

1. A completed and signed Claim form and Attending Physician's Statement.
2. **For Hospital/Intensive Care/Hospital Services Coverage -** All UB92 hospital bills, HCFA1500 physician's bills, physician's superbills (these are standard billing statements used by your provider of service).
3. FOR HMO or Medicare Insureds, please submit verification of confinement from the hospital if a UB92 hospital bill is not available.
4. **For Surgical, Anesthesia or Ambulance Coverage –** Send copy of the bills.
5. ALL BILLS MUST INCLUDE A DIAGNOSIS FROM YOUR PROVIDER OF SERVICE.
6. Evidence of change of name of Member, Dependent or Beneficiary. (if applicable)

**Return Proofs of Loss** (*listed above*) to:

Monumental Life Insurance Co
PO Box 17004
Baltimore, MD 21297-0428

**Note: If you need additional space in order to complete the Claim Form, please attach a separate sheet of paper with your responses.**

**When the loss was due to…**

**an accident,** a copy of the police report, or Emergency Medical Services report must be furnished.

**Cancer,** a pathology report verifying a malignancy MUST BE PROVIDED for all initial claim submissions.

This claim form has been sent to you as requested in anticipation of a claim being filed. Monumental Life Insurance Company is unable to begin processing your claim until all completed forms and documents are received by Monumental Life Insurance Company. If we do not receive the completed claim form within 30 days of your receipt of the claim form, we will assume you no longer wish to file a claim. If you need assistance, please contact us at the toll free number as noted below.

**NOTICE TO ILLINOIS INSUREDS**

For policies which also provide death benefits - If an Insured was issued a policy in Illinois or was a resident of Illinois at the time of death, interest will accrue on the proceeds payable because of the death of the Insured starting from the date of death. The rate of interest will be 9% on the total amount payable, or the face amount if payments are to be made in installments, until the total payment or first installment is paid, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss. If payment is made within the 15 days of the receipt of due proof of loss, the 9% interest is not payable.

## If you have any questions, please call us toll free at:

## 1-800-233-4697

# FRAUD WARNING NOTICES

**Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines, and/or imprisonment.**

**Alaska**, **Minnesota**, **New Hampshire**: 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.

**Arkansas**, **Louisiana**, **Maryland, New Mexico, Texas, 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 civil fines and criminal penalties.

**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 any 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**, **Maine**, **Virginia**, **Tennessee, Washington**: WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company 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.

**Delaware**, **Idaho**, **Indiana**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false or misleading information is guilty of a felony.

**Florida**: Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self insured program files a statement of claim or an application containing any false or misleading information commits insurance fraud, punishable as provided in section 817.234.

**Hawaii:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**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.

**Kentucky, 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.

**New Jersey**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil 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 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.

**Oregon:** Any person who knowingly and with intent to defraud, files a claim for benefits may be guilty of insurance fraud and may be subject to prosecution.

Monumental Life Insurance Company

# CLAIM FORM

**HOSPITAL INDEMNITY OR CANCER INSURANCE**

| **MEMBER INFORMATION** | | | | |
|---|---|---|---|---|
| Name (Last, First, Middle) | | Please also list all other names by which the Member is known: | | |
| Address: Is this a new address: _____ | City | State | Zip | Phone: (_____)_____ |
| Date of Birth: | Social Security Number (required): | Sex: _____Male ____Female | | Marital Status: |
| Your Citizenship: (_____) U.S. (_____) Other (please indicate) _____ | | | | |
| Policy Number: | Certificate Number: | How are premiums paid? | | Name of Association: |

| **DEPENDENT INFORMATION (ONLY COMPLETE IF CLAIM IS FOR DEPENDENT)** | | | | |
|---|---|---|---|---|
| Name (Last, First, Middle) | | Please also list all other names by which the Dependent is known: | | |
| Address: Is this a new address: _____ | City | State | Zip | Phone |
| Date of Birth: | Social Security Number (required): | Sex: _____Male ____Female | | Marital Status: |
| Relationship to Member: Spouse ____ Child _____ Other _____ | | Is the Dependent a full time student? _____ Yes _____ No | | |
| Name of the School: | Address of the School: | Phone Number: (_____)_____ | | |
| Dependent Citizenship: (_____) U.S. (_____) Other (please indicate) _____ | | | | |

| **DOES THE MEMBER HAVE OTHER INSURANCE POLICIES? IF YES PLEASE LIST** | | | |
|---|---|---|---|
| Insurance Company: | Name of Association: | Policy #: | Certificate #: |
| | | | |

**CLAIM DETAILS**

Date of Loss: _____

Have you claimed benefits for this condition previously? _____

If loss due to an Accident describe fully HOW and WHERE. _____

If loss due to Sickness: (Describe) _____

Emergency Treatment? _____ Yes _____ No If Hospital Confined: Admission date:_____ Discharge date: _____

Hospital Name:_____ Hospital Phone: (_____)_____

Address: _____ Physician Name: _____

City _____ State_____ Zip code: _____ Phone: (_____)_____

I am filing this claim as the ☐ Member ☐ Executor ☐ Administrator ☐ Guardian ☐ Power of Attorney
If you are claiming as other than Member, please provide proof of your authority to represent the Member.

I certify that the foregoing statements and answers on this form are complete and true to the best of my knowledge.

**Signature**: _____ **Date**: _____

| **THIS SECTION TO BE COMPLETED BY PLAN ADMINISTRATOR** | | | |
|---|---|---|---|
| Name of Member: | Policy #: | Certificate #: | Policy Type: |
| Amount of Insurance: | Effective Date: | Paid to Date: | Date Insurance terminated: |
| Your name & Title: | Your Address: | Your Phone #: | Signature: |

Monumental Life Insurance Company

# ATTENDING PHYSICIAN'S STATEMENT FORM

| PATIENT INFORMATION | | |
|---|---|---|
| Name (Last, First, Middle) | | Please also list all other names by which the Patient is known: |
| Date of Birth: | Social Security Number: | Address: |

## THIS SECTION IS TO BE COMPLETED BY YOUR PHYSICIAN

| 1. Date of First Symptoms: _____/_____/_____ | 2. Date First Consulted for this Condition: _____/_____/_____ | 3. Date Condition First Diagnosed: _____/_____/_____ |
|---|---|---|

4. Has Patient ever been previously treated for this condition or related condition? _____ If yes, give date and diagnosis or prior advice and treatment:

5. Name and Address of Physician who referred this Patient:

6. Name and Address of Hospital where services were rendered:

7. Name and Address of Nursing Home where services were rendered:

| 8. For Services Performed in Hospital: | 9. For Services Performed in Nursing Home: |
|---|---|
| Admission date:____/____/____ Discharge date: ____/____/_____ | Admission date:____/____/___ Discharge date: ____/____/___ |

Inclusive Dates Patient was confined in an Intensive Care Unit of Hospital: From:____/____/____ to: ____/____/_____

Please provide names and Addresses of other Physicians currently treating Patient:

Diagnosis of illness or injury requiring services (Relate Diagnosis to procedure by reference to numbers 1, 2, 3, etc in column D

1.

2.

3.

| 13. A | B | C | | D | E |
|---|---|---|---|---|---|
| Date of each Service | Place of Service: * See code Below | Describe surgical or Medical procedures and other Services furnished for each date given | | DX. No. | CHARGES |
| | | Procedure Code | (Explain unusual circumstances) | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | |
|---|---|---|---|
| * Place of Service Codes<br>1-(IH) Inpatient Hospital<br>2-(OH) Outpatient Hospital<br>3-(O) Doctors Office | 4-(H) Patient's home<br>5-Psychiatric Day Care Facility<br>6-Psychiatric Night Care facility | 7-(NH) Nursing Home<br>8-(SNF) Skilled Nursing Home<br>9-Ambulance | O-(OL) Other Locations<br>A-(IL) Independent Laboratory<br>B-(ASC) Ambulatory Surgical Center |

Date ___/____/___ Physician's name (print):_____ Degree: _____ Signature: _____

Address:_____ City/State: _____ZIP: _____

Phone: (_____)_____ Individual Practitioners SS#: _____Employer Tax ID #:_____

Monumental Life Insurance Company

Claim # _____

# AUTHORIZATION

***FOR OFFICIAL USE ONLY***

## FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ **(hospital/doctor/other medical provider)** to disclose the following protected health information from the medical records of the patient identified below. I understand that information used or disclosed pursuant to this authorization could be subject to **re-disclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. You are hereby authorized to give to the Company specified below, or its representatives, copies of any records or data which have to do with the **physical or mental health including drug, alcohol, psychiatric, HIV infection or AIDS related treatment**. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

Social Security Number**:** _____ Date of Death: _____

Address: _____

Information to be disclosed to: Monumental Life Insurance Company or their Representative: _____

Disclose the complete records including the following information for treatment dates**:** _____ to _____**:**

| | | | |
|---|---|---|---|
| ☐ Admission Summary | ☐ Consults | ☐ Office Records | ☐ Death Summary |
| ☐ Discharge Summary | ☐ X-Ray | ☐ Emergency Reports | ☐ Toxicology |
| ☐ History & Physical | ☐ Laboratory | ☐ Operative Reports | ☐ Autopsy |
| ☐ Outpatient Reports | ☐ Pathology | ☐ EMS Report | ☐ _____ |

**The above information is disclosed for the purpose of processing an insurance claim.**

I understand I may **revoke this authorization** at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization **expires 2 years from the date signed**; unless otherwise noted here: _____.

## IMPORTANT – If patient is deceased, please INITIAL one of the statements below:

_____ I am the Administrator/Executor for the deceased & Letters of Testamentary (or comparable documents) are attached.
Initial here

_____ There is no court appointed Administrator/Executor and I am the next of kin.
Initial here

I understand that I am not required to sign this authorization. The above named health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

I also authorize any doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient named above, including financial institutions, and law enforcement agencies to give Monumental Life Insurance Company or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs.

_____ _____
**Signature of Legal Representative/Next of Kin/Claimant** **Date**

_____ _____
**Printed name of Legal Representative/Next of Kin/Claimant** **Relationship or authority to act for Patient**

_____ _____
**Witness** **Date**

## PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS