Colonial Life℠

Making benefits count.

Claim Form and Instructions

Fax to: Claims 1-800-880-9325

From:_____
Fax Number:_____
Date:_____
Number of pages:_____

Your disability or critical illness claim must be filed within 12 months of your date of loss.

What can I do to avoid delays?

Missing information will delay the processing of your claim. Please be sure you:

- ❑ **Sign** and return the attached Certification on page 3 and Authorization on page 7.
- ❑ **Complete** the sections that apply to your specific claim. Please have your **doctor and employer** complete their sections, if applicable.
- ❑ **Enclose** copies of all **bills** connected with your claim, if applicable.

When should I expect a reply?

- If you are filing a claim for a sickness or health condition occurring within the first 6 to 24 months of your policy/certificate (based on policy requirements), we need to determine if the condition is **pre-existing**. We may have to write for this information which may delay your claim. **Please include the signed authorization with your claim and ask your doctor to promptly respond to our request for medical information.**

We will call you to advise when your claim information is in processing. Mail time is a large contributor to the time it takes for our response to reach you. **Mail** may take up to four or five days each way.

To avoid mail delays:

- **Fax** your claim to us at **1.800.880.9325**. If you are faxing your claim, please make a copy of the back pages and fax all pages of the claim together. **Please do not mail the original document but keep it for your records.** Please allow **at least two business days** for our automated service center to be updated with information confirming receipt of your fax. You will receive an automated call when your fax has been updated in our system.
- Have your payment returned by **overnight delivery** by initialing the Service Release below. A $18.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments of $100.00 or more. *A street address is required.* *Your check will be delivered Monday through Friday; however, the time is not guaranteed.***

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below as indicated.

I authorize Colonial Life & Accident Insurance Company to facilitate processing this claim by releasing its details if he/she is inquiring on my behalf.

X _____ local sales representative (initial) _____ plan administrator (initial) _____ spouse, family member or significant other (initial)

_____ (initial) I authorize Colonial Life & Accident Insurance Company to communicate information on the status of this claim through **electronic messaging** at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/answering machine. I will program phone number 1.800.325.4368 into my phone to avoid calls being blocked.

_____ (initial) Yes, please deduct the $18.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from my claim payment for this claim. This fee does not include weekend delivery. I understand this fee will be deducted for **future payments** for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under $100.00 will be sent by regular mail.

Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying Colonial Life in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by Colonial Life & Accident Insurance Company.

- Benefits are payable to you unless we receive a written authorization from your provider to assign benefits to them. This is called an **assignment**. If you wish to assign your benefits, please attach a signed written request.
- If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

CLAIMANT NAME: *X*_____ **SOCIAL SECURITY NUMBER:**_____

Colonial Life is the marketing brand for Colonial Life & Accident Insurance Company. Visit us online at coloniallife.com

Mail to: **Colonial Life & Accident Insurance Company**
PO Box 100195
Columbia SC 29202-3195

Fax to: 1.800.880.9325
If you fax your claim, there is no need to mail the original. Reminder: Please copy the back pages and fax all the pages of the claim together.

WELLNESS/HEALTH SCREENING

If you wish to file a **Wellness/Cancer Screening claim for a test performed within the past 12 months**, you'll need to submit the type and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number. **You may:**

- **FILE BY PHONE!** Call **1.800.325.4368** and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week, **or**
- **SUBMIT ON THE INTERNET** using the Wellness Claim Form at **coloniallife.com**, or
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "**Wellness Test**."

FAX this to us at **1.800.880.9325** ***or*** **MAIL** to P.O. Box 100195, Columbia SC 29202.
If your Wellness/Cancer Screening test was more than one year ago, you must fax or mail us a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.

Please note: If your cancer policy includes a second part to the screening benefit, bills for tests covered and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

CANCER

If you do not have a **Cancer** policy, please complete the sections that apply to your coverage. To file for benefits under a cancer policy, please complete page 3 and check **cancer** at the top of this page:

- For *Internal Cancer* – **Attach** a copy of the **pathology report** from your *initial* diagnosis.
- Attach copies of itemized statements for all medical expenses incurred relating to the diagnosis and treatment of your malignancy. Please clearly write your name and social security number on each bill.
- For *Skin Cancer* – Attach a copy of your pathology report for *each date of service* a lesion was biopsied and/or removed.
- *Transportation and Lodging* – Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.
- ***If you are claiming disability, please have your employer and doctor provide any applicable information under SECTIONS D & E.***

If you have any questions while completing this claim form, please call us at 1.800.325.4368. We will assist you with the information and forms needed to successfully complete this process.

Your claim must be filed within 12 months of your date of loss.
Please **check** the type of claim you are filing below:

- ❑ **Wellness** - See top of page 2
- ☒ **Cancer** - See below.
- ❑ **Routine Pregnancy** - See page 4 if you are filing for benefits for normal post-delivery disability. Pages 5 and 6 are not necessary.
- ☒ **Total Disability** - (Accident/Sickness/Pregnancy complications) Sections D & E contain parts for both your employer and doctor to complete. See pages 5 and 6. A disability only claim form is now available at our website, www.coloniallife.com.
- ❑ **Accidental Injury** - Section A, page 4, requests specific information from you about the circumstances of your injury.
- ❑ **Hospital Confinement, Intensive Care, Outpatient Surgery and/or Rehabilitation Unit** - Have your doctor complete Section C, page 5, and send copies of your hospital, outpatient surgery, and/or Rehabilitation Unit bills.

This claim is for: ☒ Self ❑ Spouse ❑ Dependent: if over 18, name of school_____

Name of Claimant_____ Name of Policyholder (if not claimant) _____

Social Security Number: _____ **Social Security Number:** _____

Date of Birth (mm/dd/yyyy): ____/____/_____ ❑ Male ❑ Female Date of Birth (mm/dd/yyyy): ____/____/_____ ❑ Male ❑ Female

Policy Number: _____

Mailing Address _____
Street (Apt. #) City State Zip

(must include street address for overnight delivery)

Has your address changed since we last heard from you? ❑ YES ❑ NO

Home Phone Number: (_____) _____ Work Phone Number: (_____) _____

Fax Number: (_____) _____ Policyholder email Address:_____

If you are claiming disability, please list the dates you were unable to work: from ____/_____/_____ to ____/_____/_____

***Please print* INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL**

Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).

1._____
Full name of treating doctor

_____
Mailing Address

_____
City State Zip Code

(____)_____ (____)_____
Phone number Fax number

2._____
Full name of referring doctor/hospital

_____
Mailing Address

_____
City State Zip Code

(____)_____ (____)_____
Phone number Fax number

3._____
Full name of primary doctor

_____
Mailing Address

_____
City State Zip Code

(____)_____ (____)_____
Phone number Fax number

4._____
Other

_____
Mailing Address

_____
City State Zip Code

(____)_____ (____)_____
Phone number Fax number

CERTIFICATION

Policyholder/Employee's Name_____ **Social Security #**_____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the "Claim Fraud Warning and State Versions" form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. 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.

PLEASE ALSO SIGN AND DATE THE AUTHORIZATION ON PAGE 7.

X_____/_____/_____ X_____ X_____
Date (mm/dd/yyyy) PATIENT SIGNATURE POLICYHOLDER/EMPLOYEE SIGNATURE

CLAIMANT NAME: X_____ **SOCIAL SECURITY NUMBER:**_____

A. ACCIDENTAL INJURY- please **complete** and **attach itemized copies** of any related **bills** including **doctor**, **ambulance, emergency room**, **hospital, and/or rehabilitation unit**. Bills should include **diagnosis** information from your medical provider.

Date of accident (mm/dd/yyyy): ____/_____/_____ **Time of accident:** _____ am / pm (circle one)

Tell us how your accident happened:

_____

_____

_____

_____

_____

Were you at work, working for wage or profit, at the time of your accident? ❑ yes ❑ no

Have you ever had a similar injury? _____If so, please tell us when (mm/dd/yyyy): _____

If you are claiming disability, please have your employer and doctor provide any applicable information under SECTIONS D & E.

To be completed and signed by your doctor

B. ROUTINE PREGNANCY (6 weeks for vaginal delivery or 8 weeks for c-section, less the elimination period)

If disabled due to complications of pregnancy, before or after delivery, complete *Section E on page 6.*

Date of Delivery (mm/dd/yyyy):_____/_____/_____ **Type delivery:** Vaginal / C-Section (circle one)

Date you first treated patient for this pregnancy (mm/dd/yyyy):_____/_____/_____

List other treatment dates for this pregnancy ____/____/____ , ____/____/____, ____/____/____ , ____/____/____

____/____/____ , ____/____/____, ____/____/____ , ____/____/____

Dates of Hospital Confinement (mm/dd/yyyy): ____/____/____ - ____/____/____

Name of Hospital: _____ Hospital Phone Number: (_____) _____

Name of doctor: _____ Phone: (_____)_____ Fax: (_____)_____

Address: _____

Email address:_____**Tax ID or SSN:** _____

Treating Doctor's Signature: _____ Date (mm/dd/yyyy): _____

Referring Physician: _____ Phone number: (_____) _____

Mailing address _____

Employer information on next page

CLAIMANT NAME: X_____ **SOCIAL SECURITY NUMBER:**_____

C. HOSPITAL CONFINEMENT, INTENSIVE CARE, SURGERY, AND/OR REHABILITATION UNIT BENEFIT(S).

Please send an itemized copy of your hospital and/or rehabilitation bill(s), which includes the *diagnosis, admission and discharge dates.* Have your doctor complete this section if your bills do not include diagnosis information. Please send a copy of the anesthesiology bill if outpatient surgery was performed.

INTENSIVE CARE / HOSPITAL CONFINEMENT / REHABILITATION UNIT

Dates of Service

Place of Confinement	**From** (mm/dd/yyyy)	**To** (mm/dd/yyyy)
Intensive Care including Coronary Care Unit		
Hospital (Private, Semi-Private, Other)		
Rehabilitation Unit		

Diagnosis/ICD-9 Code(s): _____

Hospital: _____ Phone Number (_____)_____

Hospital Address: _____

Rehabilitation Unit Address: _____ Phone Number (_____)_____

Date(s) of office visit(s) following confinement: (mm/dd/yyyy): __/____/_____ - ____/____/_____

SURGERY **Date(s) of Service**

Type of Surgery	**From** (mm/dd/yyyy)	**To** (mm/dd/yyyy)	**Procedure Description/Procedure Code**
Inpatient			
Outpatient			

Diagnosis/ICD-9 Code(s): _____

Date(s) of office visit(s) following outpatient surgery (mm/dd/yyyy): __/____/_____ - ____/____/_____

Hospital: _____ Phone Number (_____)_____

Hospital Address: _____

DOCTOR'S INFORMATION:

Signature of doctor: X _____ Date (mm/dd/yyyy): ____/____/__

Name of doctor: _____ Phone: (_____)_____ Fax: (_____)_____

Address: _____

Email address:_____Tax ID or SSN: _____

If you are claiming disability, please have your employer complete the section below and have your doctor complete SECTION E.

x **D. To be completed and signed by your *EMPLOYER:***

Name of Employer: _____ Phone Number: (_____) _____

Email address:_____ Fax Number: (_____) _____

Employee working at any other place of employment?

❑ yes ❑ no If yes, where _____

Dates this employee has been unable to work:

From: ____/____/____ am/pm To: ____/____/____ am/pm

From: ____/____/____ am/pm To: ____/____/____ am/pm

Date employee returned to main or principal duties:

____/____/____ ❑ Part time _____ Number of hours/week
❑ Full time

Date employee returned to light duty: ____/____/____

Monthly salary $_____ Hourly salary $ _____

Did the accident occur while working for wage/profit?

❑ yes ❑ no If yes, list date of injury: ____/____/____

Employee's Job Title:_____

Employee's job title duties include:

Lifting ❑ less than 15 lbs. ❑ 15 to 44 lbs. ❑ over 45 lbs.

Stooping/bending	❑ none	❑ seldom	❑ frequent
Crawling/climbing/ kneeling	❑ none	❑ seldom	❑ frequent
Reaching/pulling/ pushing	❑ none	❑ seldom	❑ frequent
Repetitive	❑ none	❑ seldom	❑ frequent
Management duties	❑ none	❑ seldom	❑ frequent

Sitting (Number of hours each day): _____

Standing/Walking (hours each day): _____

Has Workers' Compensation been approved? ❑ yes ❑ no

Name and address of Workers' Compensation carrier: _____

_____

Is modified or light duty available? ❑ yes ❑ no If yes, date available. _____

Signed: X_____ **Title:** _____ **Date (mm/dd/yyyy):** ____/____/___

(To be signed by your employer)

CLAIMANT NAME: X_____ **SOCIAL SECURITY NUMBER:**_____

x

E. DISABILITY BENEFITS. To be completed and signed by the DOCTOR treating you for this disability:

Diagnosis/ primary disabling condition/ ICD9 Code(s): _____

Secondary conditions contributing to this disability: _____

Would the patient be disabled without regards to these secondary conditions? ❑ yes ❑ no

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment: _____

Is this condition the result of an accidental injury? ❑ yes ❑ no If yes, please provide us with the date and description.

_____

Dates of Inpatient Hospital Confinement: From: ____/____/_____ To: ____/____/_____

Hospital:_____
Name Address

List any surgeries performed and submit a copy of the operative report. _____

Is this patient permanently disabled? ❑ yes ❑ no If yes, what are the permanent restrictions/limitations? _____

_____

How soon do you expect significant improvement in the patient's medical condition? _____ # weeks/months (circle one)

Dates unable to work: Full Duty: From: _____/_____/_____ To: _____/_____/_____

Dates unable to work: Partial Duty: From: _____/_____/_____ To: _____/_____/_____

List Restrictions/Limitations preventing work _____

Is this patient considered to be house confined (unable to perform normal daily activities) or unable to perform 2 or more activities of daily living? Yes / No (circle one) If yes, which ADLs cannot be performed? **(dressing, eating, transferring, toileting, and meal preparation)* _____

_____

For what period? From ____/____/_____ To ____/____/____
(This information will be used in accordance with state regulations and policy provisions.)

Anticipated return to work/release date: _____ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

If due to complications of pregnancy prior to delivery, what is EDC? _____/_____/_____

Dates of office visits (mm/dd/yyyy): _____

Recommended frequency of treatment: _____

Signature of doctor: _____ **Date (mm/dd/yyyy):** ____/____/_____ **Patient #:** _____

Name of doctor: _____ Phone: (_____)_____ Fax: (_____)_____

Specialty: _____

Address: _____

Email address:_____**Tax ID or SSN:** _____

_____
Full name of referring doctor

_____
Mailing Address City State Zip Code

(_____)_____ (_____)_____
Phone number Fax number

NOTE: Please make a copy of the patient's signed authorization to release information for your records. If your facility requires a special authorization, please have your patient sign the form and include it with this claim.

Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

x _____	_____	X _____	X _____
(Printed name of individual subject to this disclosure)	(Social Security Number)	(Signature)	(Date Signed)

If applicable, I signed on behalf of the insured as _____(indicate relationship). If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____	_____	_____
(Printed name of legal representative)	(Signature of legal representative)	(Date Signed)