CONTINENTAL AMERICAN INSURANCE COMPANY

Post Office Box 427* Columbia, South Carolina 29202 Phone (800) 433-3036 Fax (866) 849-2970



CANCER CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.

To prevent delays, please provide documentation from your healthcare provider to support this claim.

Please review your policy for specific benefits covered under your plan.

- ✓ Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.
- ✓ If this claim is for an individual covered by Medicaid or a state variation of 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.

Several states require that the following statement appear on the	AUTHORIZATION e claim forms:	N				
Any person who knowingly and with intent to defraud any i information, is guilty of a crime.	nsurance company, files a state	ement of claim con	taining ar	ny materi	ally false, incomplet	or misleading
I hereby certify that the answers I have made to the foregoing q included with this form.	uestions are both complete and t	rue to the best of my	/ knowledo	ge and be	lief. I have read the fra	aud notice
Policyholder's Signature:			Date	E		
Patient's Signature:			Date	:		
EMPLOYER'S NAME	LICYHOLDER/PATIENT INF	POLICYHOLDER'S E	MAIL ADDE	eee.		
		POLICYHOLDER'S E	MAIL ADDR	(ESS		
POLICYHOLDER'S NAME	POLICY NO.	SOCIAL SECURITY	NO.		DATE OF BIRTH	GENDER
POLICYHOLDER'S ADDRESS CITY	STATE	Z	IP CODE	POLICY	HOLDER'S TELEPHONE	NO.
CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE.						
PATIENT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	PATIENT'S DATE	OF BIRTH		PATIENT'S DATE OF I APPLICABLE)	EATH (IF
WHAT DATE WAS THE CANCER FIRST DIAGNOSED BY A PATHOLOG	SIST? (ATTACH A COPY OF THE PAT	HOLOGY REPORT)	HAVE YO		AD THE SAME OR A SIN	IILAR
			☐ YE	s	□ NO	
LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL AT	TENDING PHYSICIANS FOR THE CAR	NCER (PLEASE ATTAC	H A SEPAR	RATE LIST	IF ADDITIONAL SPACE	IS NEEDED)
IF THE CANCER REQUIRED HOSPITALIZATION, PROVIDE THE NAME	AND ADDRESS OF THE TREATING	FACILITY (PLEASE AT	TACH A SE	PARATE L	IST IF ADDITIONAL SPA	CE IS NEEDED)

Please sign the attached HIPAA form and return it with the completed claim form.

- Please be sure to include the following information along with this claim form:
 - Positive pathology report
 - o Itemized bills from facility or provider including diagnosis and/or procedure codes and charge amounts (Itemized bills may include but are not limited to the following claim forms: UB04, HCFA1500, etc.)
- If filing for the Lump Sum Cancer Plan, please submit a copy of the patient's birth certificate.

• Transportation/Lodging Information: To be completed if you are filing a claim for transportation or lodging: (please submit the hotel receipts and mileage information) *For additional information, please refer to your policy language.

Date	To/From	Round-trip Mileage	Type of Treatment

	ATTENDI	IG PHYSICIAN'S STATE	MENT		
PATIENT'S NAME			DATE OF BIRTH		DATE OF DEATH (IF APPLICABLE)
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIN TREATMENT FOR THIS OR A SIN		DIAGNOSIS (INCL	UDING COMPL	LICATIONS)
	YES, WHEN	•			
Has the patient been dia that diagnosed cancer)	agnosed with cancer? \[\] N	o Yes (If yes, plea	ase submit the	initial patho	logy report or exam
Type of cancer:					
Date of initial diagnosis:					
First date of treatment for	or this diagnosis:				
Name:	e, address and phone num	per of the patient's pi	rimary treating	pnysician.	
Name.		F11011	e Number		· · · · · · · · · · · · · · · · · · ·
Address:			 		· · · · · · · · · · · · · · · · · · ·
	by any other physicians? [ame(s):		Number(s):		
ii yes, piiysiciaiis ii	ame(s)	FIIONE	Nulliber(5)		
Address:					
hospital bill, UB04, or He	d to the hospital as a result CFA 1500)	_	_		nit the itemized
Hospital name					
City	State				
Did the patient undergo	surgery for this condition?	☐ No ☐ Yes (If yes	s, please submi	t a copy of	the operative report
or surgeon's bill to include] Ot at: a at 11a	ما 🗖 امانسم	
	ery performed? Office [spitai 🔲 in	ipatient Hospitai
Name of facility					· · · · · · · · · · · · · · · · · · ·
Address:			 	 	
	I chemotherapy? ☐ No ☐ ere chemotherapy was rece				
Address:					
	l oral chemotherapy?	No ☐ Yes (If yes, ple	ase submit pha	armaceutica	al statements.)
				.4:	
	I topical chemotherapy (Tre yes, please submit pharma			otion or crea	am applied to the
	I radiation therapy? ☐ No re radiation was received: _	Yes (If yes, pleas	e submit a cop	y of itemize	ed billing.)
Address:					
I haraby partify that the above of		IG PHYSICIAN'S SIGNAT		at to the best of	my knowledge and helief
NAME (ATTENDING PHYSICIAN) PL	described information is based upon re EASE PRINT	DEGREE	and is true and come	TELEPHONE	
ADDRESS		CITY		STATE	ZIPCODE
SIGNATURE		DATE		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.

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.

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.

KANSAS: 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 as determined by a court of law.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

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.

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.

RHODE ISLAND and 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.

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INSURED	POLICY NUMBER	
INSURED	TOLICI HOMBER	

AUTHORIZATION TO OBTAIN INFORMATION CONTINENTAL AMERICAN 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 for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history 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 any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or 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. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC 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 I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization 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.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

(Printed Name of Individual Subject to Disclosure)	(Date of Birth)
(Signature)	(Date Signed)
If applicable, I signed on behalf of the insured as	5.6
(Indicate relationship, legal Guardian, Power of Attorney Designee, Co	onservator, Beneficiary or personal representative.)
(Indicate relationship, legal Guardian, Power of Attorney Designee, Co (Printed Name of Legal Representative)	onservator, Beneficiary or personal representative.)