CRITICAL ILLNESS CLAIM FORM

CHUBB

ACE American Insurance Company

MAIL TO:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
www.visit-aci.com
Phone: 888-293-9229
Fax: 610-293-9299
Email: aciclaims@visit-aci.com

ENTIRE CLAIM FORM MUST BE COMPLETED AND RETURNED WITH ITEMIZED BILLS WITHIN 30 DAYS.

EDI PAYOR ID# 22384

Please be sure to send the following Information:

- ✓ Medical Documentation for your condition,
- ✓ Diagnosis (ICD9) codes,
- ✓ Signed and dated authorization

OPTIONAL SERVICE RELEASE AGREEMENT – Please **initial** below for optional services. Any other marks used (check mark, x, etc.) will not be considered as authorization and will be processed as blank.
I authorize ACE American Insurance Company to facilitate processing this claim by releasing its details to the individual inquiring on my behalf. Leave blank if you do not want anyone accessing your claim information.

_____ sales representative

_____ plan administrator

_____ spouse, family member or significant other

If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)

Section 1 TO BE COMPLETED BY POLICY OWNER		
Claimant name __Male __Female	**Birth Date**	**Claimant Social Security Number**
Relationship to Policy Owner: ___ spouse ___ dependent ___self ____domestic partner		
Policy owner (First, Last)	**Birth Date**	**Social Security Number**
Mailing Address (Street or PO Box)		**(Apartment/Unit/Lot Number)**
(City) (State) (Zip)		**Daytime Phone**
Policy owner e-mail address		
What type of illness are you claiming?	**When were you first treated for this illness?** _____ **(MM/DD/YYYY)**	
Do you have a disability policy with us? ____**Yes** ____**No** **If yes, dates you are unable to work.** **From**_____ **To**_____ **(MM/DD/YYYY) (MM/DD/YYYY)**	**Employer's Name**_____ **Telephone** _____**Fax**_____	

CERTIFICATION

Policy owner'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 Statements on page 6 of this 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. **Fraud Warning: 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 remember to also sign and date the attached authorization required to process your claim.

X_____ X_____ X_____

Claimant's Signature Policy owner's Signature Date (MM/DD/YYYY)

Treating Doctor's Name	**Phone Number**	**Fax Number**
Address (Street) **(City)** **(State)** **(Zip Code)**		
Primary Doctor's Name	**Phone Number**	**Fax Number**
Address (Street) **(City)** **(State)** **(Zip Code)**		
Referring Doctor or Hospital Name	**Phone Number**	**Fax Number**
Address (Street) **(City)** **(State)** **(Zip Code)**		
Referring Doctor or Hospital Name	**Phone Number**	**Fax Number**
Address (Street) **(City)** **(State)** **(Zip Code)**		
Referring Doctor or Hospital Name	**Phone Number**	**Fax Number**
Address (Street) **(City)** **(State)** **(Zip Code)**		

Section 2 TO BE COMPLETED BY PHYSICIAN	
Patient's Name	**Patient's Date of Birth**
For each condition listed in the chart below for which you are treating this patient, please enclose the information listed under the Medical Documentation Needed section.	
Blindness if applicable to your policy	**Medical documentation of clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or visual field restriction to 20 degrees or less in both eyes.**
Bypass Surgery as a result of Coronary Artery Disease	**Surgical report that documents procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts.**
Cancer and/or Carcinoma in situ	**A pathology report confirming the pathological diagnosis of cancer or carcinoma in situ by a certified pathologist. If a pathological diagnosis cannot be made provide medical evidence to support a clinical diagnosis of cancer or carcinoma in situ based on the study of symptoms.**
End Stage Renal Failure	**Medical documentation of regular hemodialysis or peritoneal dialysis.**
Heart Attack (Myocardial Infarction)	**Diagnosis supported by three or more of the following indicators: medical records documenting typical chest pain suggestive of heart attack; new EKG report showing changes indicative of myocardial infarction; medical reports documenting increase of specific cardiac markers typical for heart attack, or medical reports of confirmatory imaging studies. (In the event of death, an autopsy confirmation identifying heart attack as the cause of death will be accepted.)**
Permanent Paralysis (due to Covered Accident) if applicable to your policy	**Medical documentation of complete and permanent loss of the use of two or more limbs for a continuous period of 180 days.**
Stroke	**Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event and confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.**
Transplant as the result of Heart Failure	**Surgical report that documents transplant of a human heart**
Transplant as a result of a Major Organ Failure (human lung, liver, kidney or pancreas)	**Surgical report that documents transplant of the human organ.**

Section 2 (cont'd)	**TO BE COMPLETED BY PHYSICIAN**	
Patient's Name		**Patient's Date of Birth**
Provide the diagnosis(es), the date of diagnosis, and the ICD-9 code(s) for the conditions for which you are treating this patient.		
Diagnosis	**Date of Diagnosis**	**ICD-9 Code**
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	
Has this patient been treated for this same or similar condition in the past prior to this occurrence? ___Yes ___No		
Diagnosis	**First Date of Treatment**	**Referring Doctor's Name and Telephone**
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	
	_____ (MM/DD/YYYY)	
FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.		
_____ Medical Provider's Name(Please Print)		**( )_____( )_____ Phone Number Fax Number**
_____ Medical Provider's Signature		**_____ Date (MM/DD/YYYY)**

Authorization for ACE 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 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 ACE American Insurance Company (ACE) 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 ACE 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 ACE 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. ACE 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 ACE 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, ACE may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: ACE American Insurance Company, c/o Administrative Concepts, Inc (ACI), P.O. Box 4000, Collegeville, PA 19426-9000.

You may refuse to sign this form; however, ACE 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_____ XXX-XX-_____ _____
(Signature) (Social Security Number — last 4 digits) (Date of Birth)

_____ _____
(Printed name of individual subject to this disclosure) (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)

Authorization