

CRITICAL ILLNESS CLAIM FORM

CHUBB

CHUBB Group of
Insurance Companies

MAIL TO:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: 888-293-9229
Fax: 610-293-9299
Email: aciclaims@visit-aci.com
www.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 CHUBB Group of Insurance Companies 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Claimant Social Security Number	
Relationship to Policy Owner: <input type="checkbox"/> spouse <input type="checkbox"/> dependent <input type="checkbox"/> self <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____
Claimant's Signature

X _____
Policy owner's Signature

X _____
Date (MM/DD/YYYY)

<u>Treating Doctor's Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Primary Doctor's Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Referring Doctor or Hospital Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Referring Doctor or Hospital Name</u>	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
<u>Referring Doctor or Hospital Name</u>	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
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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 CHUBB Group of Insurance Companies

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

You may refuse to sign this form; however, CHUBB 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

IMPORTANT NOTICE

Notice to Alaska Claimants: 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.

Notice to Arizona Claimants: 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.

Notice to Arkansas Claimants: 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.

Notice to California Claimants: 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.

Notice to Colorado Claimants: 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.

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

Notice to District of Columbia Claimants: 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.

Notice to Florida Claimants WARNING: 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.

Notice to Idaho Claimants: 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.

Notice to Indiana Claimants: 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.

Notice to Kentucky Claimants: 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.

Notice to Maine Claimants: 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.

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

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: 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.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to New Mexico Claimants: 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.

Notice to New York Claimants Fraud Warning: 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 material 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.

Notice to Ohio Claimants: Any person who, with the 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.

Notice to Oklahoma Claimants: 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.

Notice to Oregon Claimants WARNING: Any person who, knowingly and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

Notice to Pennsylvania Claimants Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Notice to Rhode Island Claimants WARNING: 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.

Notice to Virginia Claimants: 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.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.