# CANCERCARE
# INSTRUCTIONS FOR FILING CLAIMS

Dear Policyholder:

Thank you for choosing USAble Life to provide your protection against the increasing costs of cancer treatment. We have included these instructions to assist you in the event you need to file a claim. You can obtain claim and authorization to release medical forms from our website at www.usablelife.com or contact a Personal Account Representative at the phone number listed below. **Please remember claims must be received within 90 days of diagnosis of cancer, ICU/CCU admission, or date of mammogram or diagnostic tests.**

## CANCER OR SPECIFIED DISEASE CLAIMS

1. Complete and sign the Insured's Statement on the Cancer and Specified Disease Benefits claim form, CL-CSD.
2. Answer **ALL** questions, or state "not applicable". Incomplete forms will be returned.
3. Have your physician complete the Attending Physician's Statement. Be sure **ALL** questions are answered and the form is signed.
4. Attach itemized bills for all treatment. We are sorry, but we cannot accept billing summaries or Explanations of Benefits from other insurance claims.
5. Sign and return the Authorization for Release of Medical Records form.

## HOSPITAL CORONARY/INTENSIVE CARE CONFINEMENT BENEFITS - *Rider Only*

1. Complete and sign the Insured's Statement on the Coronary Care or Intensive Care claim form CL-HIP/ICU-CCU. Answer **ALL** questions or state "not applicable". Incomplete forms will be returned.
2. Have your physician complete the Attending Physician's Statement. Be sure **ALL** questions are answered and the form is signed.
3. Attach itemized hospital bill. We are sorry but we cannot accept billing summaries or Explanations of Benefits from other insurance claims.
4. Sign and return the Authorization for Release of Medical Records form.

Note: This form should be completed only for ICU/CCU confinement from an accident or non-cancer or specified disease. ICU/CCU confinement for cancer and specified disease claims should be filed on Form CL-CSD.

## WELLNESS BENEFITS

1. Please mail us an ITEMIZED bill for the covered test or service. Payment will be mailed to the address on the bill. Please make sure this address is correct. (Do not rely on your physician or hospital to file your claim.) You can also obtain instructions on how to file wellness claims on our website.
2. You do NOT need a claim form or Authorization to Release Medical Records form to collect reimbursement for these benefits BUT the following information must be submitted:
   - Insured's Name and Social Security Number
   - Policy Number (very important)
   - Patient's Name, Date of Birth, and Social Security Number
   - Date of Service
   - Current mailing address

   You may write the above on the itemized bill for submission.
3. Incomplete claims cannot be processed and will be returned to you.

**Mail Claim Forms and Bills To:**
Claim Department
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Cancer Claim Fax: (501) 235-8416
Wellness Claim Fax: (501) 235-8400
Email: claims@usablelife.com

**For Questions or Assistance Contact:**
Personal Account Representative
USAble Life
1-800-370-5856
8:00 a.m. - 4:30 p.m. Central Time
Email: custserv@usablelife.com

***Warning:*** *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.*

USAble Life℠

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8416
E-mail: claims@usablelife.com

For H.O. Use Only
Eff _____
PTD _____
Plan Code _____
Issue Age _____

# Statement of Claim
# Cancer and Specified Diseases

**Instructions:**
1. **Please make sure all questions on Insured's statement are completed in full.**
2. **Authorization must be signed and currently dated.**
3. **Physician Statement on page 2 must be completed.**

## INSURED'S STATEMENT

| Insured Name (Last, First) | Policy Number (Very Important) | | |
|---|---|---|---|
| Home Address (City, State, Zip) | Telephone Numbers<br>Home Work | | |
| Patient Name (Last, First) | Patient's SSN | Date of Birth | Relation to Insured |

Describe symptoms: _____

Date of first treatment: _____

Name and address of first doctor seen: _____

Names and addresses of all doctors and hospitals consulted for **this** condition (Use separate sheet if necessary):

| Physician | Address, City, State and ZIP |
|---|---|
| | |
| | |
| | |

Have you ever had this or similar condition before? ☐ Yes ☐ No

If yes, give particulars: Date: _____

Describe: _____

Names and addresses of all doctors seen for any condition in the past five years (Use separate sheet if necessary):

| Physician | Address, City, State and Zip | Condition |
|---|---|---|
| | | |
| | | |

### Authorization to Obtain Information

I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (or its representatives) and to permit them to examine and copy such information. I understand that USAble Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the company.

A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

**FRAUD WARNING**: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

**Date:** _____ **Signature of Patient:** _____
(Parent/Guardian if Minor)

## Please have your Attending Physician complete page 2 and attach itemized copies of your bills.

**FRAUD WARNING**: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

# ATTENDING PHYSICIAN'S STATEMENT

## Please answer all questions and attach itemized bill for all services to date.

Diagnosis and concurrent conditions (Include ICD Code)

| Date symptoms first appeared | Date patient first consulted you |
|---|---|
| | |

If hospitalized, date _____

☐ Inpatient ☐ Outpatient

Hospital Name _____

City, State _____

Have you treated this patient for other conditions? ☐ Yes ☐ No

If yes, give dates and describe _____

_____

_____

Has patient ever had same or similar condition? ☐ No ☐ Yes, Date _____

Was patient referred to you? ☐ Yes ☐ No

If yes, name and address of referring doctor _____

_____

| Physician's Signature | | | Date |
|---|---|---|---|
| Physician's Name | | | Degree |
| Address | | | Telephone |
| City | State | Zip | Fax |

# ⚠ USABLE LIFE℠ | FRAUD NOTICE

**FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE:**
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. Please see below for special notices required by state law.

**AL Residents Only:** 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.

**AK Residents Only:** Any 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.

**AZ Residents Only:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CA Residents Only:** 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.

**CO Residents Only:** 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.

**DE, ID, IN, OK Residents Only:** 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.

**DC Residents Only:** 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.

**FL Residents Only:** 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 of the third degree.

**KS Residents Only:** 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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.

**KY Residents Only:** 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.

**ME and TN Residents Only:** 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 and denial of insurance benefits.

**MD, RI, TX Residents Only:** 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.

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

**NH Residents Only:** 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.

**NJ Residents Only:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**OH Residents Only:** 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.

**OR Residents Only:** 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 may be guilty of a crime and subject to fines and confinement in prison.

**PA Residents Only:** 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.

**VT Resident Only:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**VA and WA Residents Only:** 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.

**▼ SIGN AND DATE BELOW**

I have read and understand the Fraud Warning that applies to my state of residence.

| LAST NAME, FIRST NAME, MI *(PRINTED)* | SIGNATURE | TODAY'S DATE |
|---|---|---|

USAble Life℠

# AUTHORIZATION | To Disclose, Obtain and Use Personal Information

Read and sign below.

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the MIB, Inc., benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

**Signature**

Sign and date this form.

**I have executed this authorization intending that it will be effective on and after:**

Date

•

Signature

•

Printed name

•

*Return original with your claim and retain a copy of this authorization and claim form for your records.*