

Fax to: Claims 1.800.880.9325

From: _____ Number of pages: _____



Making benefits count.

Or Mail to:
P.O. Box 100195
Columbia SC 29202-3266

Universal Claim Form

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 Colonial Life 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

_____ I want Colonial Life to update me on the status of my claim through electronic messaging at my home phone number indicated on this form. Messages will be left with anyone that answers the phone or on my answering machine. To avoid blocked calls, I should program the number 1.800.325.4368 into my phone.

_____ Yes, I want **ALL** payment(s) for this claim sent by overnight delivery. I understand payment(s) under \$100.00 cannot be sent overnight and an \$18.00 fee, which is subject to rate increases by carrier and **does not include weekend delivery, will be deducted from my claim payment(s). We are unable to overnight mail to a P.O. Box and you must notify us in writing to discontinue this service.**

*WELLNESS/HEALTH SCREENING

If you wish to file a **Wellness/Health Screening claim for a test performed within the past 12 months**, 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 you file by telephone or internet, please retain a copy of the medical information and/or your receipt if needed for further verification.

If your Wellness/Health 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 covered tests 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

Please complete the sections that apply to your coverage.

- 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. Also, please include a copy of your itemized bills that provide the surgical procedure code(s) and charges for each lesion removed. This information should provide all doctors complete names, mailing addresses and telephone numbers.
- **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 5 & 6.**

Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others require the following statement to appear on this claim form.

Fraud Warning : Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Arizona Residents : 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.

California, Rhode Island, Texas and West Virginia Residents : For your protection, California, Rhode Island, Texas and West Virginia 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 Residents : 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.

District of Columbia and Maryland Residents : 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 Residents : 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.

Kentucky : For your protection, Kentucky law requires the following to appear on this 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.

Maine, Tennessee, Virginia and Washington Residents : 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.

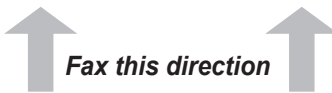
New Jersey and New Mexico : Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents : 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.

Pennsylvania Residents : 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

Oregon Residents : Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Puerto Rico Residents : 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 (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If 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.



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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
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Relationship to Policy Owner: spouse dependent self domestic partner

Policy owner (First, Last)	Birth Date	Social Security Number
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Mailing Address (Street or PO Box)	(Apartment/Unit/Lot number)
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(City)	(State)	(Zip)	Home telephone number ()
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Policy owner e-mail address (<i>*Please print</i>)	Work telephone number ()
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If you are claiming disability, please list the dates you were unable to work.

From _____ To _____
(MM/DD/YYYY) (MM/DD/YYYY)

<u>Treating Doctor's Name</u>	Phone Number	Fax Number
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Address (Street) (City) (State) (Zip Code)

<u>Primary Doctor's Name</u>	Phone Number	Fax Number
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Address (Street) (City) (State) (Zip Code)

<u>Referring Doctor or Hospital Name</u>	Phone Number	Fax Number
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Address (Street) (City) (State) (Zip Code)

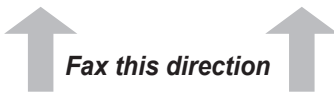
SECTION 2 TO BE COMPLETED BY POLICY OWNER

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 the accident occurred (not when it was treated) _____ (MM/DD/YYYY)	Have you been treated for the same or similar condition prior to this occurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ (MM/DD/YYYY)
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Check One: _____ On-Job _____ Off-Job

Description of accident (if auto accident, attach a copy of the traffic report)



CERTIFICATION

Policy owner 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 2 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)

SECTION 3 TO BE COMPLETED BY PHYSICIAN
ROUTINE PREGNANCY (6 weeks for vaginal delivery or 8 weeks for c-section, less the elimination period)

Date of Delivery _____ (MM/DD/YYYY)
____ Vaginal ____ C-section

Hospital Admission Date: _____ (MM/DD/YYYY)

Hospital Discharge Date : _____ (MM/DD/YYYY)

First Date of Treatment, Advice, Medication : _____ (MM/DD/YYYY)

List other Date of Treatments, for this pregnancy : _____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY)

_____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY)

Doctor's Name _____ Doctor's Phone : ()
Fax : ()

Tax ID or SSN: _____

Doctor's Address (Street) _____ (City) _____ (State) _____ (Zip Code)

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.

Doctor's Signature _____ Date: _____ (MM/DD/YYYY)

Referring Physician's name and address _____ Doctor's Phone : ()
Fax : ()

Hospital Name _____ Hospital Phone
()

Hospital's Address (Street) _____ (City) _____ (State) _____ (Zip Code)



SECTION 4 Hospital Confinement/Hospital Intensive Care Unit Confinement Benefits

Refer to your certificate for required proof of loss requirements. Ask your medical provider to complete the following section.
Include a copy of the hospital bill(s) showing the admission and discharge dates, the daily room charge(s) and the medical expenses incurred. Please send a copy of the anesthesiology bill if outpatient surgery was performed.

Patient's name		Patient's DOB	
Hospital Name		Phone Number : ()	
Hospital Address: (Street)	(City)	(State)	(Zip Code)

Admitting Doctor's Name :		Phone Number : ()	
Admitting Doctor's Address: (Street)	(City)	(State)	(Zip Code)

Hospital Confinement Dates : From _____ To _____
(MM/DD/YYYY) (MM/DD/YYYY)

Intensive Care Unit Confinement Dates : From _____ To _____
(MM/DD/YYYY) (MM/DD/YYYY)

Rehabilitation Unit : From _____ To _____
(MM/DD/YYYY) (MM/DD/YYYY)

Surgery: From _____ To _____ Inpatient Outpatient
(MM/DD/YYYY) (MM/DD/YYYY)

Procedure Description/Procedure Code :	
Admitting Diagnosis/ICD-9 Code :	Secondary Diagnosis/ICD-9 Codes :

Date(s) of Doctor Office Visit(s) following outpatient surgery :

(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

If hospital confinement is for pregnancy or pregnancy complications, please provide the date the pregnancy was diagnosed _____
(MM/DD/YYYY)

Date of delivery : _____ Type of delivery : ___ Vaginal ___ C-section Procedure Code for delivery _____
(MM/DD/YYYY)

Referring Doctor's Name:		Phone Number : ()	
Referring Doctors Address: (Street)	(City)	(State)	(Zip Code)

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.

Doctor's Signature (completing this form): _____ Date : _____
(MM/DD/YYYY)

Tax ID or SSN : _____ Phone Numbers: () Fax Number: ()



SECTION 5 TO BE COMPLETED BY PHYSICIAN

Patient's Name _____ Patient's DOB _____

What primary condition prevents the patient from working? _____

Symptoms: _____ Objective Findings: _____

Date first treated for this condition ____/____/____ (MM/DD/YYYY) If pregnancy, what is EDC? ____/____/____ (MM/DD/YYYY)

Is condition due to accident? Yes No If yes, date and description of accident ____/____/____ (MM/DD/YYYY)

Are any secondary conditions preventing the patient from working? Yes No If yes, what are these secondary conditions? _____

Would the patient be disabled without regard to these secondary conditions? Yes No

When did symptoms first appear? ____/____/____ (MM/DD/YYYY) Date of new patient consultation ____/____/____ (MM/DD/YYYY) Date of patient's last visit ____/____/____ (MM/DD/YYYY)

List any test(s) performed and submit a copy of the results. _____

List any surgeries performed with the date and procedure code (CPT).
(Attach a copy of the operative report)

Restrictions (What the patient SHOULD NOT do) _____

Limitations (What the patient CANNOT do) _____

How soon do you expect significant improvement in the patient's medical condition? 1-2 months 3-4 months 5-6 months more than 6 months Expected return to work (MM/DD/YYYY)

Dates (MMDDYYYY) unable to work full-time From: _____ To: _____ Dates (MMDDYYYY) unable to work part-time From: _____ To: _____ Actual date released to return to work. ____/____/____ (MM/DD/YYYY)

Does this patient have permanent restrictions/limitations? Yes No If not employed, list dates of house confinement: From ____/____/____ (MM/DD/YYYY) To ____/____/____ (MM/DD/YYYY) House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.

Please check the activities of daily living that the patient is unable to perform:
 dressing eating meal preparation toileting continence bathing transferring

Dates of Office visit (for this condition) _____ How often do you see the patient? _____

Have you referred patient for other types of consultation Yes No Name and address of Specialist _____

Dates of Hospitalization (for this condition) _____ Name and Address of Hospital _____

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Signature of Physician _____ Date (MMDDYYYY) _____ Physician's Specialty _____

Telephone Number () _____ Fax Number () _____ Tax ID or SSN _____

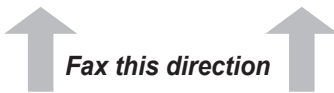
Physician/Group Name _____ Patient Account Number _____

Mailing Address _____ Do you accept Medical Records request by Fax? Yes No

Was patient referred to you by another physician? Yes No Do you have authorization on file to release information to Colonial Life? Yes No

Provide the following information for referring doctor: Name: _____ Phone number () _____

Mailing Address _____ Fax number () _____



SECTION 6 TO BE COMPLETED BY EMPLOYER

Employee name _____	Date last worked _____ (MM/DD/YYYY)
Hire date _____ Social Security Number _____ or Date of Birth _____	Dates employee unable to work (Full-time) From _____ AM/PM To _____ AM/PM (MM/DD/YYYY) (MM/DD/YYYY)
Average number of scheduled hours per week _____	

Date sick leave was exhausted _____ (MM/DD/YYYY)	Was employee at work when the accident or sickness occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dates approved for FMLA (if eligible) From _____ To _____ (MM/DD/YYYY) (MM/DD/YYYY)	Is a Workers' Compensation claim being filed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date employment terminated _____ (MM/DD/YYYY)	Name and phone number of Workers' Compensation carrier:

For hourly employees: Hourly rate of pay _____ Hours worked per week _____	For salaried employees: Annual salary _____
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If salary includes commissions, attach a breakdown of commissions for the twelve months prior to date last worked.

Date returned to work: Full-time _____ (MM/DD/YYYY)	Part-time _____ (MM/DD/YYYY)	<input type="checkbox"/> 20 hours or less	Expected return to work _____ (MM/DD/YYYY)
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Employee's job title: _____

Employee's duties include: _____

Lifting	<input type="checkbox"/> Less than 15 lbs.	<input type="checkbox"/> 15 to 44 lbs.	<input type="checkbox"/> over 45lbs.
Stooping/bending	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Crawling/kneeling	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Reaching/pulling/pushing	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Repetitive motion	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent
Management Duties	<input type="checkbox"/> none	<input type="checkbox"/> seldom	<input type="checkbox"/> frequent

Sitting (number of hours each day): _____ Standing (number of hours each day) _____

Walking (number of hours each day): _____ Climbing Stairs/Ladders (number of hours each day) _____

Who should we contact for updates on return to work status? Name/Phone/E-mail (**Please print*) _____

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Signed by _____ Title _____

Print name _____ Date _____
(MM/DD/YYYY)

Telephone Number () _____ Fax Number () _____

E-mail Address (**Please print*) _____

