COLONIAL
SUPPLEMENTAL INSURANCE

for what happens next®

FAX 1-800-880-9325

P. O. Box 100195
Columbia, SC 29202-3195

Please complete the section that applies to you.
Please allow two weeks after mailing your claim for us to process.

Please sign and return the enclosed authorization and the certification to avoid delay.

Express Filing of Pregnancy Claim

This is for the expected recovery period only. If you are totally disabled prior to delivery or beyond 6 weeks for vaginal delivery and 8 weeks for C-section delivery, please complete a claim form for disability.

	Policy Number (If known)	Phone Number

1. Policyholder Name (First, Middle, Last)	Social Security Number	Birthdate (mm/dd/yyyy)

2. Address (Street)	(City)	(State)	(Zip Code)	☐ **Check Here If New Address**

3. Policyholder email address:

4. Patient's name:	Patient's Social Security #

Please have your doctor complete the following:

5. Delivery Date (mm/dd/yyyy): ❑ Vaginal ❑ C-section	First Date (mm/dd/yyyy) of Treatment, Advice, Medication

6. Doctor's Name & Address (Please Print)	Phone # ( ) Fax # ( )

7. Doctor's Signature	Date (mm/dd/yyyy)	Tax Identification #

8. Referring Physician's Name & Address (Please Print)	Phone # ( ) Fax # ( )

9. Hospital Name	Hospital Admission Date: Hospital Discharge Date:

10. Hospital Address	Phone # ( ) Fax # ( )

CERTIFICATION

Policyholder/Employee's Name _____ Social Security Number _____

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.

_____	_____	_____
DATE (mm/dd/yyyy)	POLICYHOLDER/EMPLOYEE SIGNATURE	PATIENT SIGNATURE

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Express Filing of Cancer Screening/Wellness Benefit

For express filing, you must send the following information from your doctor:

- **The type of cancer wellness screening that was performed, date of service, and copy of bill.**
- **If you are treated at a non-cost incurred facility, please furnish verification from the facility of the date and type of test performed.**

This claim is for ❑ Self ❑ Spouse ❑ Dependent

1. Policyholder Name (First, Middle, Last)			Patient Name-if not self (First, Middle, Last)
Policyholder Social Security Number			Patient Social Security Number
Birthdate (mm/dd/yyyy)			Birthdate (mm/dd/yyyy)
Address (Street/Apt #)			☐ Check Here If New Address
City	State	Zip	Home Phone # ( )

2. Policyholder email address:

3. Type of Test Performed* Date Test Performed (mm/dd/yyyy)

4. Doctor's Name			Doctor's Phone # ( ) Doctor's Fax # ( )
5. Doctor's Address (Street)	(City)	(State)	(Zip Code)

***Please Note: Your policy(ies) does not provide benefits for routine physical examinations. Please review your policy(ies) for the list of covered tests.**

CERTIFICATION

Policyholder/Employee's Name _____ Social Security Number _____

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.

DATE (mm/dd/yyyy) POLICYHOLDER/EMPLOYEE SIGNATURE PATIENT SIGNATURE