



Department of Administrative Services

CRITICAL ILLNESS CLAIM FORM

INSTRUCTIONS

Critical Illness Claim

Please complete the Policyholder/Claimant's Information section and attach a copy of the claimant's birth certificate. If additional space is needed to include all names of doctors or hospitals in attendance, please attach a separate piece of paper for your additional listings. Please read the authorization section and sign in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. Failure to sign the authorization will delay the processing of your claim. Have your attending physician complete the section on the reverse side of the form that corresponds to the specific critical illness for which the claim is being made. If you are filing for cancer under the critical illness plan, please attach the pathology report that confirms the diagnosis.

Health Screening Claim

If you are filing for the health screening benefit, complete the first three lines of the Policyholder/Claimant Information section and the Health Screening Information section. Attach documentation indicating the type of test performed, the date the test was performed, and the charges incurred.

Send all claims to: Continental American Insurance Company
Critical Illness Claims Processing Unit
Post Office Box 427
Columbia, South Carolina 29202 800-433-3036

POLICYHOLDER/CLAIMANT'S INFORMATION					
EMPLOYER'S NAME					
POLICYHOLDER'S NAME		POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX
POLICYHOLDER'S ADDRESS				POLICYHOLDER'S TELEPHONE NO.	
CLAIMANT'S NAME		RELATIONSHIP TO THE POLICYHOLDER	CLAIMANT'S DATE OF BIRTH	CLAIMANT'S DATE OF DEATH (IF APPLICABLE)	
WHAT IS THE SPECIFIC CRITICAL ILLNESS FOR WHICH THE CLAIM IS BEING MADE		WHEN WAS THE CRITICAL ILLNESS FIRST DIAGNOSED	HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION: <input type="checkbox"/> YES <input type="checkbox"/> NO		
LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIANS FOR THE CRITICAL ILLNESS (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)					
IF THE CRITICAL ILLNESS REQUIRED HOSPITALIZATION, PROVIDE THE NAME AND ADDRESS OF THE TREATING FACILITY (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)					
HEALTH SCREENING INFORMATION					
WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:					
<input type="checkbox"/> STRESS TEST ON A BICYCLE OR TREADMILL	<input type="checkbox"/> FASTING BLOOD GLUCOSE TEST	<input type="checkbox"/> MAMMOGRAPHY			
<input type="checkbox"/> SERUM CHOLESTEROL TEST (HDL AND LDL)	<input type="checkbox"/> BONE MARROW TESTING	<input type="checkbox"/> BLOOD TEST FOR TRIGLYCERIDES			
<input type="checkbox"/> CA 15-3 (BLOOD TEST FOR BREAST CANCER)	<input type="checkbox"/> CA 125 (BLOOD TEST FOR OVARIAN CANCER)	<input type="checkbox"/> BREAST ULTRASOUND			
<input type="checkbox"/> CHEST X-RAY	<input type="checkbox"/> COLONOSCOPY	<input type="checkbox"/> CEA (BLOOD TEST FOR COLON CANCER)			
<input type="checkbox"/> HEMOCULT STOOL ANALYSIS	<input type="checkbox"/> THERMOGRAPHY	<input type="checkbox"/> FLEXIBLE SIGMOIDOSCOPY			
<input type="checkbox"/> PSA (BLOOD TEST FOR PROSTATE CANCER)	<input type="checkbox"/> SERUM PROTEIN ELECTROPHORESIS (MYELOMA)	<input type="checkbox"/> PAP SMEAR			
<input type="checkbox"/> OTHER					
DATE THE HEALTH SCREENING TEST WAS PERFORMED					
AUTHORIZATION					
Several states require that the following statement appear on the claim forms:					
Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.					
I have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information of me, to give to Continental American Insurance Company or its legal representative, any and all such information. This Information is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug or alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. I UNDERSTAND the information obtained by use of the Authorization will be used by Continental American Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Continental American Insurance Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE that this Authorization shall be valid for the duration of my claim.					
Policyholder's Signature:		Date:	Claimant's Signature:		Date:

CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT			
PATIENT'S NAME		DATE OF BIRTH	DATE OF DEATH (IF APPLICABLE)
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? <input type="checkbox"/> YES, WHEN _____ <input type="checkbox"/> NO	DIAGNOSIS (INCLUDING COMPLICATIONS)	
CANCER/CARCINOMA IN SITU			
DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED)		WAS THE CANCER/CARCINOMA IN SITU <input type="checkbox"/> PATHOLOGICALLY DIAGNOSED, OR <input type="checkbox"/> CLINICALLY DIAGNOSED	
IF THE CANCER/CARCINOMA IN SITU WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA IN SITU WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.			
MYOCARDIAL INFARCTION (HEART ATTACK)			
DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:			
1. ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKG'S AND REPORTS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2. WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHOSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3. DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4. DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)			
CORONARY ARTERY BYPASS SURGERY			
DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT CONDITION CAUSED THE NEED FOR CORONARY ARTERY BYPASS SURGERY?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?		
MAJOR ORGAN TRANSPLANT			
DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, LUNG, KIDNEY, OR PANCREAS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?		
STROKE			
DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTEBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN) REPORT OR MAGNETIC RESONANCE IMAGING (MRI) REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?)			
RENAL FAILURE			
DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS)			
WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE?		WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?	
ATTENDING PHYSICIAN'S SIGNATURE			
I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.			
NAME (ATTENDING PHYSICIAN) PLEASE PRINT		DEGREE	
ADDRESS		TELEPHONE NUMBER	
CITY		STATE	ZIPCODE
SIGNATURE		DATE	
		MEDICAL ID#	

Dependent Child Benefits

Cystic Fibrosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cerebral Palsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cleft Lip or Cleft Palate	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Spina Bifida	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Accident Claim Instructions

1. Please complete sections 1 through 6.
2. Read and sign the Authorization, section 8. The authorization will be used in obtaining information needed to process your claim. Failure to complete the Authorization will result in a delay in processing.
3. If your loss is the result of an Accident, please provide a complete description of your accident. If the accident was a motor vehicle accident attach a copy of the police or accident report. If you were injured in an on-job or occupational injury, attach a copy of the first report of injury filed with your employer.
4. If you were first treated at an emergency room, please attach a copy of the discharge papers from the hospital in order for us to verify the first date of treatment.
5. Please attach a copy of all bills and supporting documents related to the treatment of your loss. The medical bills and supporting documents should include the diagnosis, the specific procedure or treatment the covered insured received, the date of service, and the amount charged for physician services, emergency room treatment and supplies. If you are filing for hospital confinement benefits, attach a copy of the itemized hospital bill showing the number of days of hospitalization or an admission and discharge summary.
6. If you are filing during the first year of your coverage effective date and subject to a pre-existing investigation, complete the enclosed pre-existing statement form in full and return to our office with your claim form.

PART A POLICYHOLDER/CLAIMANT'S STATEMENT

1	EMPLOYER'S NAME		POLICYHOLDER'S E-MAIL ADDRESS		
2	POLICYHOLDER'S NAME	POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX
3	POLICYHOLDER'S ADDRESS STREET		CITY	STATE	ZIP CODE
4	CLAIMANT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	RELATIONSHIP TO POLICYHOLDER	POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)	
5	DESCRIBE WHEN AND HOW YOUR ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS.				
6	IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION <input type="checkbox"/> NO <input type="checkbox"/> YES		HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? <input type="checkbox"/> NO <input type="checkbox"/> YES STATUS <input type="checkbox"/> APPROVED <input type="checkbox"/> PENDING <input type="checkbox"/> DENIED		
7	DATE SYMPTOMS FIRST APPEARED	DOCTOR TREATED OR REFERRED BY WITHIN THE LAST YEAR:			
		<u>DATE</u>	<u>NAME</u>	<u>ADDRESS</u>	<u>CITY</u> <u>STATE</u> <u>ZIP CODE</u> <u>TELEPHONE NO.</u>
		IF HOSPITALIZED WITHIN THE LAST YEAR:			
		<u>DATE</u>	<u>NAME</u>	<u>ADDRESS</u>	<u>CITY</u> <u>STATE</u> <u>ZIP CODE</u> <u>TELEPHONE NO.</u>

AUTHORIZATION

8	Several states require that the following statement appear on the claim forms: Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime. I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.	
	Policyholder's Signature: _____	Date: _____
	Claimant's Signature: _____	Date: _____