Georgia®
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: ☐ YES ☐ 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:

☐ STRESS TEST ON A BICYCLE OR TREADMILL	☐ FASTING BLOOD GLUCOSE TEST	☐ MAMMOGRAPHY
☐ SERUM CHOLESTEROL TEST (HDL AND LDL)	☐ BONE MARROW TESTING	☐ BLOOD TEST FOR TRIGLYCERIDES
☐ CA 15-3 (BLOOD TEST FOR BREAST CANCER)	☐ CA 125 (BLOOD TEST FOR OVARIAN CANCER)	☐ BREAST ULTRASOUND
☐ CHEST X-RAY	☐ COLONOSCOPY	☐ CEA (BLOOD TEST FOR COLON CANCER)
☐ HEMOCULT STOOL ANALYSIS	☐ THERMOGRAPHY	☐ FLEXIBLE SIGMOIDOSCOPY
☐ PSA (BLOOD TEST FOR PROSTATE CANCER)	☐ SERUM PROTEIN ELECTROPHORESIS (MYELOMA)	☐ PAP SMEAR
		☐ 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:

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Department of Administrative Services

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?	DIAGNOSIS (INCLUDING COMPLICATIONS)
	☐ YES, WHEN_____. ☐ NO	

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 ☐ PATHOLOGICALLY DIAGNOSED, OR ☐ 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.	☐ YES	☐ NO
2.	WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHYSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT.	☐ YES	☐ NO
3.	DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.	☐ YES	☐ NO
4.	DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?	☐ YES	☐ 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.	☐ YES	☐ 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.	☐ YES	☐ 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 VERTERBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY.	☐ YES	☐ 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.	☐ YES	☐ 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?	☐ YES	☐ 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?	☐ YES	☐ 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	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIPCODE
SIGNATURE	DATE	MEDICAL ID#	

Dependent Child Benefits		
Cystic Fibrosis	☐YES	☐NO
Cerebral Palsy	☐YES	☐NO
Cleft Lip or Cleft Palate	☐YES	☐NO
Spina Bifia	☐YES	☐NO

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia,South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970 Email: csc@caicworksite.com

CLAIM FORM

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
☐ NO ☐ YES

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?
☐ NO ☐ YES STATUS ☐ APPROVED ☐ PENDING ☐ DENIED

7
DATE SYMPTOMS FIRST APPEARED

DOCTOR TREATED OR REFERRED BY WITHIN THE LAST YEAR:
DATE | NAME | ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NO.

IF HOSPITALIZED WITHIN THE LAST YEAR:
DATE | NAME | ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NO.

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: _____