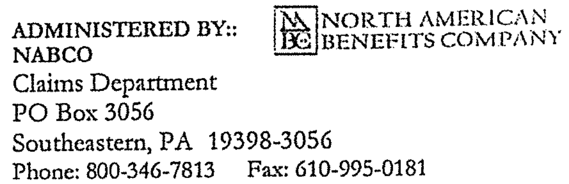
ADMINISTERED BY::
NABCO
Claims Department
PO Box 3056
Southeastern, PA 19398-3056
Phone: 800-346-7813 Fax: 610-995-0181



NOTE: Please read this before submitting a claim.

Instructions for filling out a Critical Illness Benefit form

- This form is to be used when filing for Critical Illness benefits.
- There are two sections to this form. The first section must be completed by the Insured and the second portion must be completed by the primary physician treating the Insured.
- This form must be completed in its entirety as well as signed and dated in all applicable sections. Incomplete claim forms will result in a delay in the processing of your claim.
- You are required to provide medical records documenting all treatment related to this condition from all treatment providers consulted within the timeframe beginning three months prior to the date of diagnosis of the critical illness through present date. Lack of receipt of all relevant medical records as noted above will result in a delay in the review of your application.
- Once completed this form should be submitted to the address indicated below:

North American Benefits Company (NABCO)
Claims Department
PO Box 3056
Southeastern, PA 19398-3056
(800) 346-7813
Fax: (610) 995-0181

- The furnishing of this form, or its acceptance by Madison National Life Insurance Company, Inc. , must not be construed as an admission of any liability by the Company or a waiver of any of the conditions of the insurance contract.

MAIL CLAIMS TO:
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CRITICAL ILLNESS BENEFIT CLAIM FORM

By furnishing forms and investigating the claim, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

CLAIMANT STATEMENT

Name of Insured (print): ____________________

Date of birth: __________ ☐Male ☐Female Social security number: __________

Group Name: __________ Date last actively at work: __________

Name of Claimant and relationship (if different than the insured): __________

Date of birth: __________ ☐Male ☐Female Social security number: __________

Address: __________ Telephone number: __________

City: __________ State: ______ Zip: ______ Email address: __________

Please indicate the illness which you believe will qualify you to receive Critical Illness benefits:

____

____

Have you ever had the same or similar condition in the past? ☐No ☐Yes If yes, give name and address of the treating physician and the approximate timeframe when you were previously treated:

____

____

Please specify each of the physicians that have treated you for your reported Critical Illness:

1) Physician / Facility Name:	Specialty:
Address	Phone Number:
Medical record department fax number:	Date Last treated:
2) Physician / Facility Name:	Specialty:
Address	Phone Number:
Medical record department fax number:	Date Last treated:
3) Physician / Facility Name:	Specialty:
Address	Phone Number:
Medical record department fax number:	Date Last treated:

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper):

____

____

If you have been treated at a hospital or similar institution, please supply the following information:

Name and Address of Hospital	Date of Admission	Date of Discharge

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Claimant's Signature ____________________ Date __________

FRAUD WARNING: 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, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia, Wisconsin and Wyoming.

STATE SPECIFIC FRAUD WARNINGS

ALABAMA WARNING: 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.
ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on the is form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: 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.
COLORADO WARNING: 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 damage. 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 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 WARNING: 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 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.
LOUISIANA WARNING: 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.
MAINE WARNING: 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.
MARYLAND WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
NEW HAMPSHIRE WARNING: 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.
NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NEW MEXICO WARNING: 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 civil fines, and criminal penalties.
OHIO WARNING: Any person who, with 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.
OKLAHOMA WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
PENNSYLVANIA WARNING: 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.
TENNESSEE & VIRGINIA WARNING: 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.
WASHINGTON WARNING: 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.

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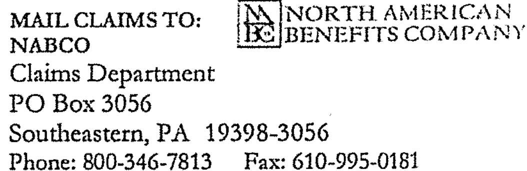

Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization but, if you do not, Madison National Life Insurance Company may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits.

Name (print): ______________________ Date of Birth: ____________ Telephone number: ______________

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: ______________________ Specialty: ______________
   Address ______________________ Phone Number: ______________
2) Provider / Facility Name: ______________________ Specialty: ______________
   Address ______________________ Phone Number: ______________
3) Provider / Facility Name: ______________________ Specialty: ______________
   Address ______________________ Phone Number: ______________
4) Provider / Facility Name: ______________________ Specialty: ______________
   Address ______________________ Phone Number: ______________

To: **NABCO**
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This form serves as an authorization for Madison National Life Insurance Company to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from ____________ through two years from the date of this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from ____________ through two years from the date of this form.

Also this form provides Madison National Life Insurance Company and any benefit plan administrators, the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (example Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance Company for the review of my claim for benefits.

I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life Insurance Company and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance Company may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance Company may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance Company in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance Company at any point during the review of my claim or during any appeals that may take place as explained above.

I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance Company may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature ______________________ **Date** ______________

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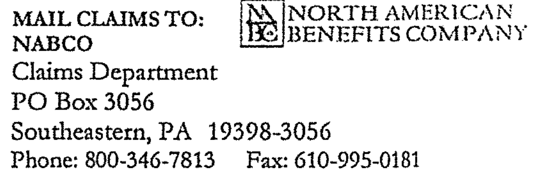

CRITICAL ILLNESS ATTENDING PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

We are in the process of evaluating a claim for Critical Illness Benefits for your patient. In order to determine benefit eligibility, we must request that this form be fully completed. This form must be approved and signed by a physician.

Patient Name:______________________________ Date of Birth______________

Address:____
Street City State Zip

Social security number:______________Telephone number:______________Policy Number ____________

DIAGNOSIS / HISTORY

Primary diagnosis: ______________________ ICD-10 code: ____________
Secondary diagnosis: ______________________ ICD-10 code: ____________
List any additional diagnoses and ICD codes related to this condition: ______________________
List All Symptoms: ______________________

Patient's Dominant Hand : ☐ Right ☐ Left

Date symptoms first appeared: ____________ Date of first visit to you for this condition: ____________
Date of most recent visit: ____________ Date of next visit: ____________

Has your patient ever had the same or similar condition? ☐No ☐Yes If yes, indicate when and describe:

____

TREATMENT PLAN

Planned course of treatment (please include expected duration, surgeries, therapy, etc.): ______________________

____

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper:

____

If patient was hospitalized, please provide dates: Admitted: ____________ Discharged: ____________
Admitting diagnosis: ______________________ ICD-10 code: ____________
Discharge diagnosis: ______________________ ICD-10 code: ____________
Name of hospital: ______________________ Name of physician seen at hospital: ____________
Address: ______________ City: ______________ State: ________ Zip Code: ________

************************************PLEASE READ CAREFULLY************************************

MEDICAL RECORDS WILL BE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. PLEASE ATTACH COPIES OF ALL MEDICAL RECORDS PERTAINING TO THIS DIAGNOSIS AND TREATMENT INCLUDING LABORATORY DATA AND RESULTS OF DIAGNOSTIC TESTS CONFIRMING THE DIAGNOSIS AND SEVERITY OF THE CONDITION, OFFICE VISIT NOTES, SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THE PAST TWO YEARS. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

Physician's signature: ______________________ **Date:** ____________

Physician's name (please print) ______________________ Specialty: ____________

Address: ______________ City: ______________ State: ________ Zip Code: ________

Physician Tax ID Number ______________________

Phone number: ______________ **Medical record department fax number:** ______________