# CRITICAL ILLNESS CLAIM FORM

## INSTRUCTIONS

Georgia™
State Personnel Administration

CAIC
CONTINENTAL AMERICAN INSURANCE COMPANY

**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 STATE OF GEORGIA / STATE PERSONNEL ADMINISTRATION

| 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:

# FRAUD WARNING NOTICES

For use with Claim Forms

## PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**ALASKA:** A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**ARIZONA:** 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.

**ARKANSAS:** 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.

**CALIFORNIA:** 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:** 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.

**DELAWARE:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**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**: 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.

**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing Any false, incomplete, or misleading information commits a felony.

**KENTUCKY:** 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:** 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:** 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:** Any person who knowingly and 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.

**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

## FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

## PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**NEW MEXICO:** 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.

**NEW YORK:** 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.

**OHIO:** 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.

**OREGON:** 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 may be guilty of insurance fraud.

**PENNSYLVANIA**: 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.

**PUERTO RICO:** 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 dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should 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.

**TENNESSEE:** 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.

**TEXAS:** 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.

**VIRGINIA**: 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:** 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.

**WEST VIRGINIA:** 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.

**ALL OTHER STATES:** 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.

CAIC
CONTINENTAL AMERICAN INSURANCE COMPANY

# 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# | |
| | | | |