



# Claim Forms and Instructions for Group Critical Illness

**This claim form should be used with plans that may include Child Critical Illness, Additional Critical Illness, or Partial Benefit Critical Illness plan options.**

## Employer

### Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing the employee's request for benefits.**

As the employer, you are required to include the following documentation (as applicable):

Enrollment Form (if employee contributes to premium)

Copy of approved medical evidence of insurability, if required at the time of enrollment

Documentation of earnings – provide 3 months of payroll records

Completed form should be sent directly to UnitedHealthcare Specialty Benefits:

**Mail:**  
UnitedHealthcare Specialty Benefits  
PO Box 7466  
Portland, ME 04112-7466

**Phone:**  
800-539-0038

**Email** (email is unsecured unless you are a registered Cicso user):  
FPCustomerSupport@uhc.com

**Fax:**  
888-505-8550

**TO BE COMPLETED BY EMPLOYER**

**General Demographics**

INFORMATION ABOUT THE COVERED EMPLOYEE			
Employee's Name:		Social Security Number:	
Address:		City:	State: Zip Code:
Location/Division:	Insurance Class:	Date of Hire:	Effective Date of Coverage:
Employee Contribution to premium: Yes*      No *If EE paid please provide enrollment card		If Yes: Pre-tax Post-tax	If Post-tax: % paid by employer % paid by employee
Employee's Occupation:	Employee's Work Status: Regular scheduled hours per week Exempt                  Non Exempt Full Time                Part Time Seasonal                 Temporary		
Elected Critical Illness Benefit Amount \$	Salary Period (check one): Weekly      Bi-weekly      Semi-monthly      Monthly Premium Per Pay Period :		

EMPLOYER INFORMATION	
Employer's Name (name of policyholder, if other)	Group Policy Number
Employer's Address	City State Zip Code

**Final Signature and Certification**

Name of person completing this form	E-mail address
Title	Phone number Ext
Signature (eSignature is allowed)	Date Signed

*Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:*  
**Fax:** 888 505 8550    **Unsecured E-mail:** FPCustomerSupport@uhc.com    **Mail:** PO Box 7466 Portland ME 04112-7466



# Claim Forms and Instructions for Group Critical Illness Employee

## Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing your request for benefits.**

As the employee, you are required to include/complete the following documentation (as applicable):	
<p>Employee Critical Illness Statement</p> <p>Provide a copy of the completed Employee's Disclosure Authorization</p>	<p>Provide Attending Physician's Statement to the physician(s) treating you</p> <p>Provide a copy of the completed Employee's Authorization of Personal Representative <i>(if applicable)</i></p>

Completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits:	
<p><b>Mail:</b> UnitedHealthcare Specialty Benefits PO Box 7466 Portland, ME 04112-7466</p> <p><b>Phone:</b> 800-539-0038</p>	<p><b>Email</b> (email is unsecured unless you are a registered Cisco user): FPCustomerSupport@uhc.com</p> <p><b>Fax:</b> 888-505-8550</p>

## Employee Critical Illness Statement

**TO BE COMPLETED BY EMPLOYEE**

Please indicate what critical illness benefit you are claiming below:

Critical Illness Category	Check Box	Child Critical Illness Category	Check Box
Benign Brain Tumor		Cerebral Palsy	
Cancer (Invasive)		Cleft Lip/Palate	
Cancer (Non-Invasive)		Cystic Fibrosis	
Chronic Renal Failure		Down Syndrome	
Coma		Muscular Dystrophy	
Coronary Artery Disease		Spina Bifida	
Heart Attack			
Heart Failure			
Major Organ Failure			
Permanent Paralysis			
Ruptured Aneurysm			
Stroke			

INFORMATION ABOUT THE COVERED EMPLOYEE:					
Full Name (First, Last, Middle Initial):		Social Security Number:		Date of Birth:	
Address:		City:		State: Zip Code:	
Your Occupation:			Last Day Worked:		
Is claim for Insured Employee or Dependent? (Please check one)      Insured Employee      Spouse      Child					
INFORMATION ABOUT THE CLAIMANT:					
Claimant's Name (if other than insured employee) if not the Employee:				Social Security Number:	
Address:		City:		State: Zip Code:	
Date of Birth:	Height:	Weight:	Gender:    M    F	Date first noticed symptoms of illness/injury:	
Describe in detail, the nature of and the onset of illness:					
Date first treated for illness?		Date you were diagnosed with this illness?		Have you ever had the same or a similar condition in the past?    Yes, When?    No	
Provide the names, addresses and date you first saw the doctor(s) who are treating you now and/or have treated you for a similar condition in the past. If more space is needed, please attach additional paper.					
<b>Physician Name</b>		Phone No.:		Address	
		Fax No.:			
Specialty		Date First Seen		Date Last Seen	
				Currently Treating? Yes    No	
<b>Physician Name</b>		Phone No.:		Address	
		Fax No.:			
Specialty		Date First Seen		Date Last Seen	
				Currently Treating? Yes    No	
<b>Physician Name</b>		Phone No.:		Address	
		Fax No.:			
Specialty		Date First Seen		Date Last Seen	
				Currently Treating? Yes    No	
Were you admitted to the hospital as part of your treatment?    Yes    No    If you answered Yes, please provide information below.					
Hospital Name:			Date of Admission:		Date of Discharge:
Address		City		State    Zip Code	
Phone No.:			Fax No:		
<b>CLAIMANT OR BENEFICIARY SIGNATURE</b> (if under 18, signature of parent or guardian is required)					

**Final Signature and Certification**

<i>The above statements are true and complete to the best of my knowledge and belief. I acknowledge that I have read the applicable Fraud Warning Notice provided with this claim form.</i>	
Name of person completing this form	Phone Number
Signature (eSignature is allowed)	Date Signed

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:

**Fax:** 888 505 8550    **Unsecured E-mail:** FPCustomerSupport@uhc.com    **Mail:** PO Box 7466 Portland ME 04112-7466

(Rev. 06/18)

**DISCLOSURE AUTHORIZATION – Supplemental Health**

**TO BE COMPLETED BY EMPLOYEE**

Participant's Name \_\_\_\_\_

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome). If my Plan Administrator sponsors both a supplemental health plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or supplemental health benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, employee/employment records, earnings or finances, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 12 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or  
Claimant's Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE SIGN AND DATE IN INK**

Relationship, if other than Claimant: \_\_\_\_\_

*Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:*  
**Fax:** 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

At my request, and for my convenience, I, \_\_\_\_\_ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my critical illness claim to recognize \_\_\_\_\_ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that \_\_\_\_\_ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature:** \_\_\_\_\_

**PLEASE SIGN AND DATE IN INK**

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# CRITICAL ILLNESS CLAIM FORM

## ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

INSTRUCTIONS: PLEASE COMPLETE THE APPROPRIATE SECTION FOR THE CONDITION FOR WHICH YOU ARE TREATING THIS PATIENT AND ENCLOSE THE INFORMATION REQUESTED IN THAT SECTION. ATTACH ADDITIONAL SHEETS IF NECESSARY. IF THERE IS MORE THAN ONE CRITICAL ILLNESS (DIAGNOSIS), PLEASE USE A SEPARATE FORM FOR EACH.

### PATIENT INFORMATION

PATIENT'S NAME	DATE OF BIRTH	PATIENT'S DATE OF DEATH (IF APPLICABLE)
WHAT IS THE CURRENT CRITICAL ILLNESS (DIAGNOSIS)?	ICD-10 CODE	DIAGNOSIS DESCRIPTION (INCLUDING COMPLICATIONS)

HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE FOR THIS CONDITION OR A RELATED CONDITION?  YES; WHEN \_\_\_\_\_  NO  
HAVE YOU ADVISED YOUR PATIENT TO CEASE WORK ACTIVITIES AS A RESULT OF THIS CONDITION?  YES; DATE OF ADVISEMENT \_\_\_\_\_  NO  
IF YES, PLEASE PROVIDE PHYSICIAN'S NAME AND CONTACT INFORMATION: \_\_\_\_\_

### BENIGN BRAIN TUMOR

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ CIRCLE ONE: PATHOLOGICALLY DIAGNOSED OR NEURORADIOLOGICAL EXAM; SPECIFY TYPE: \_\_\_\_\_

### CANCER/CARCINOMA IN SITU

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ CIRCLE ONE: PATHOLOGICALLY DIAGNOSED OR CLINICALLY DIAGNOSED  
(DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WAS DIAGNOSED)

IF THE CANCER/CARCINOMA WAS PATHOLOGICALLY DIAGNOSED, PLEASE ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

### CHRONIC 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 PLACEMENT ON THE UNITED NETWORK OF ORGAN SHARING (UNOS) TRANSPLANT LIST?  YES  NO

### COMA

PLEASE NOTE THAT COMA MUST PERSIST FOR A CONTINUOUS PERIOD OF AT LEAST 14 DAYS.

DATE OF COMA DIAGNOSIS: \_\_\_\_\_ DURATION OF COMA: \_\_\_\_\_

PLEASE DOCUMENT SIGNIFICANT MEDICAL INTERVENTIONS AND LIFE SUPPORT MEASURES: \_\_\_\_\_

PLEASE INDICATE WHETHER COMA IS SECONDARY TO ANY OF THE FOLLOWING CONDITIONS:

STROKE  INJURY  MEDICALLY INDUCED  DRUG OR ALCOHOL USE

### CORONARY ARTERY DISEASE

DATE OF RECOMMENDATION FOR SURGERY TO OPEN NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH CORONARY BYPASS GRAFTS (arterial or venous), BALLOON ANGIOPLASTY, LASER ANGIOPLASTY, ATHERECTOMY OR PLACEMENT OF A STENT: \_\_\_\_\_

OR

DATE OF RECOMMENDATION FOR SURGERY TO OPEN NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH CORONARY BYPASS GRAFTS (arterial or venous), BALLOON ANGIOPLASTY, LASER ANGIOPLASTY, ATHERECTOMY OR PLACEMENT OF A STENT WAS NECESSARY AND RECOMMENDED IF THE PATIENT WAS WELL ENOUGH TO UNDERGO PROCEDURE: \_\_\_\_\_

### HEART ATTACK

DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

1. ARE ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH NEW AND ACUTE MYOCARDIAL INFARCTION?  
PLEASE ATTACH A COPY OF THE EKG'S AND REPORTS.  YES  NO
2. WERE SPECIFIC CARDIAC MARKERS ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL?  
PLEASE ATTACH A COPY OF THE LAB REPORT.  YES  NO
3. DID THE DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES?  
PLEASE ATTACH COPIES OF ANY APPLICABLE REPORT.  YES  NO
4. DID THE PATIENT HAVE SYMPTOMS CONSISTENT WITH MYOCARDIAL INFARCTION?  
DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION) \_\_\_\_\_  YES  NO

### HEART FAILURE

DATE OF CONFIRMATION OF HEART FAILURE DIAGNOSIS: \_\_\_\_\_

DATE PLACED ON THE UNITED NETWORK OF ORGAN SHARING (UNOS) TRANSPLANT LIST: \_\_\_\_\_

IS PATIENT A CANDIDATE FOR THE RECOMMENDED PROCEDURE?  YES  NO

# CRITICAL ILLNESS CLAIM FORM

## ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

### MAJOR ORGAN FAILURE

#### LIMITED TO LUNG, PANCREAS OR LIVER

DATE OF CONFIRMATION OF MAJOR ORGAN FAILURE DIAGNOSIS: \_\_\_\_\_ ORGAN IMPACTED (circle involved organs): LUNG PANCREAS LIVER

DATE PLACED ON THE UNITED NETWORK OF ORGAN SHARING (UNOS) TRANSPLANT LIST: \_\_\_\_\_

IS THE PATIENT A CANDIDATE FOR THE RECOMMENDED PROCEDURE?

YES  NO

### PERMANENT PARALYSIS

DID THE PATIENT SUFFER TOTAL AND PERMANENT LOSS OF THE USE OF TWO OR MORE LIMBS (arms or legs or a combination) DUE TO A SICKNESS FOR A CONTINUOUS PERIOD OF AT LEAST 30 DAYS WHICH IS NOT THE RESULT OF OR DUE TO A STROKE OR INJURY?

YES  NO

### RUPTURED ANEURYSM

#### LIMITED TO CEREBRAL, CAROTID, THORACIC AORTIC OR ABDOMINAL AORTIC

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ TYPE OF ANEURYSM: \_\_\_\_\_

### STROKE

DID THE PATIENT HAVE A STROKE, MEANING A CEREBROVASCULAR EVENT RESULTING IN MEASURABLE PERMANENT NEUROLOGICAL DAMAGE OR IMPAIRMENT INCLUDING INFARCTION OF BRAIN TISSUE, HEMORRHAGE AND EMBOLISM FROM AN EXTRACRANIAL SOURCE?

YES  NO

STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERERBROBASILAR ISCHEMIA.

DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS?

YES  NO

PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE VIA ONE OF THE FOLLOWING DIAGNOSTICS: COMPUTED AXIAL TOMOGRAPHY (CT SCAN) REPORT, MAGNETIC RESONANCE ANGIOGRAPHY (MRA) REPORT, MAGNETIC RESONANCE IMAGING (MRI) REPORT, POSITRON EMISSION TOMOGRAPHY (PET) REPORT OR AN ARTERIOGRAPHY/ANGIOGRAPHY REPORT.

### CHILD CRITICAL ILLNESS CATEGORIES\*

#### CEREBRAL PALSY

##### PEDIATRICIAN (Specialist in neurodevelopmental disorders) OR BOARD CERTIFIED NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF DEVELOPMENTAL SCREENING EVALUATIONS OR ANY ADDITIONAL DIAGNOSTICS THAT MAY HAVE BEEN PERFORMED.

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ DESCRIPTION OF CLEFTING (circle one): UNILATERAL BILATERAL

PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ANY PRENATAL ULTRASOUNDS.

#### CYSTIC FIBROSIS

##### LICENSED PEDIATRICIAN OR PULMONOLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ SWEAT CHLORIDE CONCENTRATION: \_\_\_\_\_

PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ALL DIAGNOSTIC REPORTS TO INCLUDE BUT, NOT LIMITED TO SWEAT CHLORIDE CONCENTRATION TESTING, CHEST X-RAYS, SINUS X-RAYS, LUNG FUNCTION TESTING OR SPUTUM CULTURE.

#### DOWN SYNDROME

##### LICENSED PEDIATRICIAN OR PHYSICIAN FAMILIAR WITH DOWN SYNDROME DIAGNOSIS SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ PLEASE PROVIDE MEDICAL RECORDS WITH COPIES OF DIAGNOSTIC TEST RESULTS TO INCLUDE BUT NOT LIMITED TO, ANY PRENATAL EVALUATION, IF AVAILABLE, INCLUDE DIAGNOSTIC TEST RESULTS (AMNIOCENTESIS, CHRONIC VILLUS SAMPLING AND CORDOCENTESIS/PERCUTANEOUS UMBILICAL BLOOD SAMPLING/PUBS).

FOR DIAGNOSIS RENDERED AFTER BIRTH, PLEASE INCLUDE PHYSICAL AND/OR DEVELOPMENTAL EVALUATIONS.

#### MUSCULAR DYSTROPHY

##### PHYSICIAN FAMILIAR WITH THE DIAGNOSIS AND/OR TREATMENT OR NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ALL DIAGNOSTIC REPORTS TO INCLUDE ELECTROMYOGRAPHY AND MUSCLE BIOPSY RESULTS.

#### SPINA BIFIDA

##### PHYSICIAN FAMILIAR WITH THE DIAGNOSIS AND/OR TREATMENT SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: \_\_\_\_\_ PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ALL DIAGNOSTIC REPORTS. IF DIAGNOSIS WAS MADE DURING PREGNANCY, INCLUDE DIAGNOSTIC TEST RESULTS INCLUDING ULTRASOUND REPORTS, AMNIOCENTESIS AND/OR MATERNAL SERUM ALPHA FETOPROTEIN (MSAFP) TEST.

\*In California, a signature by a Physician who is qualified in the applicable filed of Medicine is acceptable. Not available in Colorado.

### ADDITIONAL CRITICAL ILLNESS CATEGORIES

#### AMYOTROPHIC LATERAL SCLEROSIS

##### BOARD CERTIFIED NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS ACCORDING TO MUSCULAR DYSTROPHY ASSOCIATION (MDA) CRITERIA: \_\_\_\_\_

CURRENT STAGE ACCORDING TO MDA CRITERIA (circle one): EARLY MIDDLE LATE

#### COMPLETE BLINDNESS

##### LICENSED OPHTHALMOLOGIST SIGNATURE REQUIRED

DATE THAT DIAGNOSIS WAS CONFIRMED: \_\_\_\_\_

CORRECTED VISUAL ACUITY: LEFT EYE \_\_\_\_/\_\_\_\_ RIGHT EYE \_\_\_\_/\_\_\_\_  
VISUAL FIELD SEVERITY: LEFT EYE \_\_\_\_/\_\_\_\_ RIGHT EYE \_\_\_\_/\_\_\_\_



# CRITICAL ILLNESS CLAIM FORM

## ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

### COMPLETE LOSS OF HEARING

#### AUDIOLOGIST OR PHYSICIAN SIGNATURE REQUIRED

DATE THAT DIAGNOSIS WAS CONFIRMED: \_\_\_\_\_ IS HEARING LOSS TOTAL AND PERMANENT?  
 AUDITORY THRESHOLD (frequency of 500-4000 cycles): LEFT EAR \_\_\_\_\_ RIGHT EAR \_\_\_\_\_

YES  NO

### ADVANCED ALZHEIMER'S

#### BOARD CERTIFIED NEUROLOGIST SIGNATURE REQUIRED

DATE THAT DIAGNOSIS WAS CONFIRMED: \_\_\_\_\_  
 PATIENT REQUIRES SUBSTANTIAL ASSISTANCE IN PERFORMING THE FOLLOWING ACTIVITIES OF DAILY LIVING (circle all that apply):  
 BATHING CONTINENCE DRESSING EATING TOILETING TRANSFERRING

### ADVANCED MULTIPLE SCLEROSIS

#### BOARD CERTIFIED OR BOARD ELIGIBLE NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS USING McDONALD CRITERIA FOR CLINICAL DIAGNOSIS: \_\_\_\_\_

### ADVANCED PARKINSON'S

#### BOARD CERTIFIED OR BOARD ELIGIBLE NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS USING STANDARD STAGING CRITERIA FOR CLINICAL DIAGNOSIS: \_\_\_\_\_  
 CURRENT CLINICAL STAGE (circle one): ONE TWO THREE FOUR FIVE  
 IS THIS DIAGNOSIS SECONDARY TO ANY OF THE FOLLOWING CONDITIONS (circle all that apply): PROGRESSIVE SUPRANUCLEAR PALSY CORTICOBASAL  
 DEGENERATION MULTIPLE SYSTEM ATROPHY VASCULAR PARKINSONISM DEMENTIA WITH LEWY BODIES

### PARTIAL BENEFITS CRITICAL ILLNESS CATEGORIES

ADDISON'S DISEASE (ADRENAL HYPOFUNCTION) DATE OF CONFIRMED DIAGNOSIS: _____	LEGIONNAIRES DISEASE DATE OF CONFIRMED DIAGNOSIS: _____	OSTEOMYELITIS DATE OF CONFIRMED DIAGNOSIS: _____
AMYOTROPHIC LATERAL SCLEROSIS (LOU GHERIG'S DISEASE) DATE OF CONFIRMED DIAGNOSIS: _____	MALARIA DATE OF CONFIRMED DIAGNOSIS: _____	POLIOMYELITIS DATE OF CONFIRMED DIAGNOSIS: _____
CEREBROSPINAL MENINGITIS (BACTERIAL) DATE OF CONFIRMED DIAGNOSIS: _____	MULTIPLE SCLEROSIS (DEFINITIVE DIAGNOSIS) DATE OF CONFIRMED DIAGNOSIS: _____	RABIES DATE OF CONFIRMED DIAGNOSIS: _____
CYSTIC FIBROSIS DATE OF CONFIRMED DIAGNOSIS: _____	Is this a Clinically Isolated Syndrome (CIS)? <input type="checkbox"/> Yes <input type="checkbox"/> No	SICKLE CELL ANEMIA (EXCLUDING SICKLE CELL TRAIT) DATE OF CONFIRMED DIAGNOSIS: _____
DIPHTHERIA DATE OF CONFIRMED DIAGNOSIS: _____	MUSCULAR DYSTROPHY DATE OF CONFIRMED DIAGNOSIS: _____	SYSTEMIC SCLEROSIS (SCLERODERMA) DATE OF CONFIRMED DIAGNOSIS: _____
ENCEPHALITIS DATE OF CONFIRMED DIAGNOSIS: _____	MYASTHENIA GRAVIS DATE OF CONFIRMED DIAGNOSIS: _____	TETANUS DATE OF CONFIRMED DIAGNOSIS: _____
HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA) DATE OF CONFIRMED DIAGNOSIS: _____	NECROTIZING FASCIITIS DATE OF CONFIRMED DIAGNOSIS: _____	TUBERCULOSIS DATE OF CONFIRMED DIAGNOSIS: _____
SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) DATE OF CONFIRMED DIAGNOSIS: _____ TYPE OF LUPUS (circle one): SYSTEMIC CHRONIC CUTANEOUS/DISCOID SUBACUTE CUTANEOUS TUMID DRUG-INDUCED		

### OCCUPATIONAL HIV INJURY

DATE THAT DIAGNOSIS WAS CONFIRMED: \_\_\_\_\_ DATE OF INITIAL HIV ANTIBODY TEST: \_\_\_\_\_ RESULTS: \_\_\_\_\_  
 DATE OF FOLLOW-UP HIV ANTIBODY TEST (90-180 DAYS AFTER INJURY): \_\_\_\_\_ RESULTS: \_\_\_\_\_  
 PLEASE PROVIDE A COPY OF EACH TEST RESULT

### 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/SPECIALTY REQUIRED	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
SIGNATURE eSignature is allowed	DATE	MEDICAL ID#	

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**For claimants in Alabama:**

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.

**For claimants in Alaska:**

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

**For claimants in 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.

**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.**

**For claimants in 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.

**For claimants in Connecticut:**

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

**For claimants in 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.

**For claimants in 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.

**For claimants in 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

**For claimants in Hawaii:**

**For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.**

**For claimants in 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.

**For claimants in 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.

**For claimants in Kansas:**

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 may be guilty of fraud as determined by a court of law.

**For claimants in 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.

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**For claimants in 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.

**For claimants in Maryland:**

Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For claimants in Minnesota:**

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

**For claimants in 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.

**For claimants in New Jersey:**

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

**For claimants in 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 penalties.

**For claimants in 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.

**For claimants in Oklahoma:**

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**For claimants in Oregon:**

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 may be subject to fines and confinement in prison.

**For claimants in 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.

**For claimants in Tennessee and 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.

**For claimants in 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.

**For claimants in Vermont:**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

**For claimants in Virginia:**

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 false, incomplete, or misleading information may have violated state law.

**For claimants in All Other States:**

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.



PO Box 7466 Portland ME 04112-7466  
Tel 888 299 2070  
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## Claims Department Direct Deposit Agreement For Payment of Benefit to Financial Institution

**Section 1 (to be completed by benefit recipient)**

Name of Benefit Recipient

UHCSB Claim Number

UHCSB Policy Number

Social Security Number

Telephone Number

Address (Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

"I authorize UnitedHealthcare Specialty Benefits to direct the net amount of my benefit payment to be deposited directly by electronic funds transfer and credited to my account as indicated at the financial institution designated below. If any payments made are dated after the date of my death, I hereby authorize and direct the said financial institution on my behalf and on behalf of my executors or administrators to refund any such payments to UnitedHealthcare Specialty Benefits and to charge the same to my account."

**PLEASE ATTACH A VOIDED BLANK CHECK TO THIS FORM**

Signature of Benefit Recipient (eSignature is allowed)

Date Signed

**Section 2**

Name of Financial Institution

Address ((Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

Routing Number (9 digit number in lower left corner of check)

Bank Account Number (numbers following the Routing Number)

Type of Account

Checking

Savings (check one)