Horace Mann | Wise

GROUP WELLNESS CLAIM FORM

1-888-950-1085
wisebenefits.com

Instructions: Complete this form to file a claim for wellness, screening, diagnostic, physician consultation or similar benefits under an Accident, Cancer; Critical Illness or Hospital Indemnity Certificate. If available, please provide a copy of the statement or bill showing the service provided. The completed form should be signed and returned using the contact information at the bottom of the form.

LIST YOUR CERTIFICATE NUMBER(S) HERE:

Certificate #	Certificate #

Certificate Holder Information

NAME OF CERTIFICATE HOLDER		OCCUPATION	
ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS	☐ I would like to receive electronic correspondence concerning my claims and policies.		
PHONE Home ( ) -	Mobile ( ) -	Work ( ) -	

Patient Information

NAME OF PATIENT		DATE OF BIRTH / /	
PHONE ( ) -	RELATIONSHIP TO CERTIFICATE HOLDER ☐ Certificateowner ☐ Spouse ☐ Dependent	HEIGHT ft. in.	WEIGHT lbs.

Provider Information

NAME OF PROVIDER/PHYSICIAN	PHONE ( ) -	FAX ( ) -	
PROVIDER ADDRESS	CITY	STATE	ZIP

Claim Information

Please complete this section to indicate the nature of the services received by the above-named patient. Procedures listed below may not be covered under all policies and some policies may not include wellness, physician consultation or similar benefits. For procedures not listed, please check "Other" and describe the procedure performed in the space provided or provide the wellness screening report or physician consultation's office note.

Cancer Wellness Screening Benefit

We will pay the benefit amount shown in the Benefits Schedule if a Covered Person receives documented services for any individual or combination of the following screening exams, if or when the exam is used for the detection of Cancer.

☐ Human Papilloma Virus test	DATE
☐ Mammogram	DATE
☐ CT scan	DATE
☐ Ultrasound	DATE
☐ Manual breast exam by Medical Practitioner	DATE
☐ Pap Smear (lab only)	DATE
☐ Flexible Sigmoidoscopy	DATE
☐ X-ray	DATE
☐ Thermography	DATE
☐ Colonoscopy	DATE
☐ Virtual Colonoscopy	DATE
☐ Blood test to detect Cancer	DATE
☐ Biopsy which does not result in a diagnosis of Cancer	DATE
☐ Predictive Genetic Test	DATE
☐ Fecal Occult Blood Test	DATE
☐ Other	DATE

Accident, Critical Illness, and Hospital Wellness Benefits

We will pay the benefit amount shown in the Benefits Schedule if a Covered Person receives documented services for any individual or combination of the following screening exams.

☐ Abdominal aortic aneurysm ultrasonography	DATE	☐ Mammogram	DATE
☐ Blood test for lipids including total cholesterol, LDL, HDL, and triglycerides	DATE	☐ Pap Smear, (including ThinPrep)	DATE
☐ Bone marrow testing	DATE	☐ PSA	DATE
☐ Bone density screening	DATE	☐ Serum cholesterol test to determine level of HDL and LDL	DATE
☐ Breast ultrasound or mammography	DATE	☐ Serum protein electrophoresis (blood test for myeloma)	DATE
☐ CA 15-3 blood test for breast cancer	DATE	☐ Stress test	DATE
☐ CA 125 blood test for ovarian cancer	DATE	☐ Thermography	DATE
☐ Carotid doppler	DATE	☐ CT angiography	DATE
☐ CEA blood test for colon cancer	DATE	☐ Testicular Ultrasound	DATE
☐ Chest x-ray	DATE	☐ Smoking Cessation Program	DATE
☐ Colonoscopy	DATE	☐ Cancer Genetic Mutation test (BRCA)	DATE
☐ Electrocardiogram	DATE	☐ Skin Cancer Screening	DATE
☐ Double contrast barium enema	DATE	☐ Biopsies for Cancer	DATE
☐ Fasting blood glucose test	DATE	☐ Immunizations	DATE
☐ Flexible sigmoidoscopy	DATE	☐ Lymphocyte Genome Sensitivity Test	DATE
☐ Hemoccult stool analysis	DATE	☐ Universal blood test for cancer	DATE

By signing below, I represent that all information on this form is true and correct and that I have read the state-specific fraud warning on the following page.

(Signed) Patient _____ Date _____/_____/_____

A parent or legal guardian must sign if the patient is under the age of 18.

(Signed) Certificate Holder _____ Date _____/_____/_____

SEND THIS COMPLETED FORM TO OUR CLAIMS PROCESSING CENTER BY:

EMAIL: WiseWellnessMNL@horacemann.com **FAX:** 1-877-397-1147 **MAIL:** P.O. Box 365, Addison, TX 75001

STATE SPECIFIC FRAUD WARNINGS

Please review the following fraud warning for your state before signing the Claimant Statement on the previous page.

Alabama, Alaska, Arizona, Arkansas, Connecticut, District of Columbia, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia, Wisconsin, Wyoming - 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.

California-Warning: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent to obtain or amend insurance coverage or to make a 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.

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.

Kansas-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 insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky-Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine-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 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.

Maryland-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 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 includes any false or misleading information on an application for an insurance policy 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 & 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.

Texas-Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

Virginia-Warning: Any person who, with the 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 have violated state law.

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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This Authorization Complies with HIPAA Privacy Rule

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, Pharmacy Benefit Managers, other medically related facilities, other insurance companies, and MIB, Inc.) to disclose all medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) and all pharmacy records to employees of Madison National Life Insurance Company, Inc. and affiliated entities (including its reinsurers) involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

Madison National Life Insurance Company, Inc. and affiliated entities may disclose my medical records, and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers) for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws. I also authorize Madison National Life Insurance Company, Inc. or its reinsurers to make a brief report of my protected health information to MIB.

I understand that I may revoke this Authorization in writing, except to the extent that Madison National Life Insurance Company, Inc. or an affiliated entity has acted in reliance upon this Authorization. My revocation in writing must be submitted to:

Madison National Life Insurance Company, Inc.
Attn: Director of Compliance
P.O. Box 365 • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization, and I agree that a copy of this Authorization is as valid as the original.

_____ _____

Signature of Individual Whose Information is to be Disclosed | Date

_____ _____

Printed Name of Individual | Certificate Number