CLAIM FORM FOR CRITICAL ILLNESS INSURANCE BENEFITS

NOTICE OF CLAIM

Mail completed form(s) to:
Central United Life Insurance Company
Investors Consolidated Insurance
P.O. Box 925309, Houston, Texas 77292-5309

❑ **Employee Claim** ❑ **Dependent Claim**

Name of Insured	Date Employed (M/D/Y)	Group Policy No.	Div. No.	Certificate No.

Address (Street, City, State, Zip)	Telephone No. (Home) ( )	Telephone No. (Business) ( )
Type of Critical Illness	Date of Diagnosis/Surgery (M/D/Y):	
Name of Dependent (if applicable)	Dependent's Social Security Number	
Dependent's Address (Street, City, State, Zip)	Telephone No. (Home) ( )	Telephone No. (Business) ( )

II CLAIM AND RELATED DETAILS *(To be completed by the insured)*

1. On what date did you first notice your symptoms or medical problems that initiated the investigation leading to the diagnosis or surgery? ______

2. Give a brief description of your initial symptoms/medical problems?

3. On what date did you first consult a doctor or medical facility in connection with your illness? ______
   Name of doctor first consulted ______
   Name, address and phone number of the doctor who made the diagnosis of your illness, or performed the surgery.

4. Have you undergone any test or investigations related to the diagnosis? ❑ Yes ❑ No If YES, please provide details and dates: ______

5. Have you previously suffered from, or received treatment for , a similar or related illness? ❑ Yes ❑ No If YES, please give details, including dates ______

6. Please provide the Name, Address and Phone Number of your personal physician ______

7. Please provide details of any other doctors or specialists who have been consulted in connection with your illness
   (attach a separate sheet if additional space is needed)

Name	Address/Phone No.	Date Seen

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

Name	Address/Phone No.	Date of Admission & Discharge

9. What other treatment have you received and are you currently receiving in connection with your illness (e.g. medications, therapy, etc)?

Type of Treatment	Institution/Prescribing Physician	Dates

III GENERAL *(To be completed by the insured)*

1. Has any blood relative suffered from a similar or related illness? ❑ Yes ❑ No If YES, please indicate

Relationship	Nature of Illness	Age at which illness was first diagnosed

2. Provide details of any other insurance coverage under which an insurance benefit may be awarded for your condition. Also, please include any Workman's Compensation and Social Security Disability benefits.

Name of Insurer	Policy No.	Type of Benefit	Has a claim been filed?	Approved/Denied/Pending

3. Do you smoke or use tobacco products? Q Yes q No If YES, please indicate amount per day ______________________________
How long have you used tobacco?_____________ If NO, did you previously use tobacco products? ❑Yes ❑ No On what date did you quit? ______________________________

4. Please provide any further information that may be relevant to the claim:
____
____
____

I, the person insured, and/or the claim any if other than the insured, certify the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that by furnishing this form and investigating the claim or by accepting proofs of claim, Central United Life shall not be held to admit the validity of any claim nor the have waived any of its rights in defense of any claim arising under the polic(ies).

Any person who knowingly and with intent to defraud an 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 either fraud or a fraudulent insurance act, depending upon the laws of the applicable jurisdiction.

Date Signed ______________________________ Date Signed ______________________________

______________________________ ______________________________
SIGNATURE OF EMPLOYEE SIGNATURE OF DEPENDENT *(if applicable)*

Submit Completed Form to:
Central United Life Insurance Company
Investors Consolidated Insurance
10700 Northwest Freeway
Houston, Texas 77092

CLAIM FORM FOR CRITICAL ILLNESS INSURANCE BENEFITS

NOTICE OF CLAIM

Mail completed form(s) to:
Central United Life Insurance Company
Investors Consolidated Insurance
P.O. Box 925309, Houston, Texas 77292-5309

❑ **Employee Claim** ❑ **Dependent Claim**

Name of Insured	Date Employed (M/D/Y)	Group Policy No.	Div. No.	Certificate No.

Occupation	Last Day Worked (M/D/Y)	Reason for Stopping Work	Was insurance in force at time of Critical Illness? ❑ Yes ❑ No

Amount of Group Optional Life Insurance	Date Insured for Optional Life (attach current and past election forms)	Annual Earning as of last day worked
$		$

Name of Dependent (if applicable)

Name, Address, Phone Number and Policy Number of your Health Insurance Provider

Do you have knowledge of any circumstances of this claim that might give rise for concern as to whether this claim should be paid or about whether the claim is properly payable to the claimant? ❑ Yes ❑ No If YES, please communicate circumstances in separate covering letter.

WARNING: Any person who knowingly and with intent to defraud an 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 either fraud or a fraudulent insurance act, depending upon the laws of the applicable jurisdiction.

CERTIFICATION

I certify that the above answers are true and correct, and in the case of self-administered Group, that premiums paid correspond to the sum assured claimed. I understand that on occasion payroll or attendance records may be requested as documentation.

Name of Policyholder or Employer ______________________

Address ______________________

Telephone ______________________

Name of Policyholder or Employer Representative (please print) ______________________

Signature of Policyholder or Employer Representative ______________________

Date ______________________

CLAIM FORM FOR CRITICAL ILLNESS INSURANCE BENEFITS

NOTICE OF CLAIM

Mail completed form(s) to:
Central United Life Insurance Company
Investors Consolidated Insurance
P.O. Box 925309, Houston, Texas 77292-5309

❑ Employee Claim ❑ Dependent Claim

MAJOR ORGAN TRANSPLANT

THE CLAIMANT IS RESPONSIBLE FOR ANY FEE FOR THIS INFORMATION

Your Patient (our insured)	Date of Birth	Central United Life Policy Number(s)
Name of Owner *(if other than person insured)*		

THE POLICY'S CONTRACTUAL REQUIREMENTS

The insurance policy contains certain contractual requirements regarding the Doctor who provides the diagnosis of the patient's critical illness. Unfortunately, the Physician may not be the Insured or the Owner, or related by blood or marriage to either the Insured or Owner, or the business associate of either the Insured or the Owner. For that purpose, please answer the following so that your patient can complete his/her claim:

Do you fall into any of the above categories? ❑ Yes ❑ No If YES, please indicate relationship: ____________

Are you a medical doctor, duly licensed and practicing medicine in the United States? ❑ Yes ❑ No

IT IS VERY IMPORTANT THAT ALL QUESTIONS BE ANSWERED

1. a) How long has this person been your patient? ____________
   b) Please provide complete details of the disorder leading to your patient's transplant procedure? ____________
   c) On what date did your patient first consult you for this condition? ____________
   d) On what date did your patient first suffer symptoms of this disorder? ____________
   e) What were the symptoms? ____________
   f) On what date was the disorder first diagnosed? ____________
   g) On what date was you patient made aware of the diagnosis? ____________
   h) By Whom? ____________
   i) How long had end stage disease been present? ____________
2. Please give brief details of the transplant procedure performed, including the names and addresses (if known) of the hospital, attending surgeon and the date of the procedure. ____________
3. Please give the name and address of any other physicians consulted and hospitals attended by your patient for this or any related condition.
   Name: ____________
   Address (if known) ____________
4. Is there anything in your patient's habits or family history that increased the risk of the underlying disorder? ❑ Yes ❑ No
   If YES, please provide details. ____________
5. Please provide any other information that would be helpful in the assessment of your patient's Critical Illness claim. ____________

Thank you for your time in completing this form.

Date ____________ Signature of Doctor: ____________

Doctor's Name: ____________ (please print) Specialty: ____________ Phone (____) ____________

Complete Address: ____________

Please complete and return this form with all medical records that were requested to: Central United Life Insurance Company

General Consent Form to the Use and Disclosure of Protected Health Information

I understand that ____creates and maintains medical and related records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is my "protected health information".

I understand and consent to the use and disclosure of my Health Information by ______________________________ ________________________for the following purposes:

- My treatment: This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional.
- Payment for healthcare services provided to me: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.
- My Provider's internal operations: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

I understand and agree that:

- I have the right to review ____*Notice of Privacy Practices for Protected Health Information*, which provides a much more detailed description of information uses and disclosures, prior to signing this Consent.
- ____ may change or modify its *Notice of Privacy Practices for Protected Health Information* at any time and I have the right to obtain a revised notice of privacy practices by accessing the ________________________'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.
- I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my Provider is not required to agree to any restrictions that I may request, but if my Provider agrees, it will be bound by that restriction.
- I have the right to revoke this Consent by notifying my Provider *in writing* that I revoke this Consent unless my Provider has used or disclosed my Health Information in reliance on this Consent.
- My Provider has the right to disclose relevant Health Information to my family member, other relative, close personal friend, or anyone identified by me.

____
Signature

____
Printed Name of Patient

____
Date

____
Description of Personal Representative's Authority