Telephone: 1-888-729-5433, Ext. 2013
Fax: 1-888-843-5872
Email: CIClaims@AlwaysCareBenefits.com

NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

GROUP CRITICAL ILLNESS INSURANCE

Underwritten by: National Guardian Life Insurance Company
Administered by: AlwaysCare Benefits, Inc.

Claim Forms and Instructions

We understand that suffering a critical illness creates emotional, physical and financial challenges, and you have our commitment to provide you with responsive service during the claim process.

This packet contains forms that must be completed and signed by the Employer, Employee, Claimant, and Attending Physician. Please provide complete and legible responses to ensure your claim is processed as quickly as possible. Incomplete or illegible answers may result in delay of benefit consideration. To avoid unnecessary delays, be sure all required parts of the claim packet are completed and returned as soon as possible. You may also want to keep a copy for your records.

INSTRUCTIONS:

SECTION A This section is to be completed by your Employer. For your privacy this section should be completed first or you may detach and give to your employer separately. It MUST be returned with your claim packet.

SECTION B This section is to be completed by the Claimant (the person who was diagnosed with the Critical Illness). If the Claimant is a minor, a parent or legal guardian must complete.

SECTION C The Attending Physician's report is to be completed by the physician(s) who diagnosed and treated the Claimant for the Critical Illness. This form should be left with the physician to be mailed or emailed directly to our office with supporting documentation regarding your claim.

AUTHORIZATION The Authorization to Release Information is to be completed and signed by the patient. If the patient is not the Employee or Claimant for whom information is to be released, please attach appropriate documentation substantiating your authority. If the patient is a minor, a parent or legal guardian must complete.

SUBMIT CLAIMS TO:

By Mail: AlwaysCare Benefits, Inc.
c/o Critical Illness Claims
P.O. Box 98100
Baton Rouge, LA 70898-9100

By Fax: 1-888-843-5872

By Email: CIClaims@AlwaysCareBenefits.com

If you have any questions about completing this form, please call: 1-888-729-5433, Ext. 2013.

The furnishing of this form or its acceptance by the Company as proof must not be construed as an admission of any liability on the part of the Company, or as a waiver of any of the conditions of the insurance certificate.
If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact Customer Service at 1-888-729-5433, Ext. 2013.

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION A – Employer's Statement

(To be completed by the employer. To ensure your privacy, please have the Employer section of the claim form completed first.)

EMPLOYER INFORMATION:		
Employer Name:	**Employer Address** (including city, state, and zip):	
Group Code:	**Telephone Number:**	**Fax Number:**
Name & Address of branch where employee works (if different from above):		

EMPLOYEE INFORMATION:		
Employee Name:	**Date of Birth:** _____/_____/_____	**Date of Full Time Employment:** _____/_____/_____
Occupation:		**Work Schedule at Time Last Worked:** ☐ Full time ☐ Part time If part time: Hours worked per week ____
Was employee actively at work at the time of enrollment? ☐ Yes ☐ No		
Has the employee returned to work? ☐ Yes ☐ No If yes, what date: _____/_____/_____		
Date employment terminated (if applicable): ______/______/______		
Contribution to the cost of insurance: Does the employee contribute to the cost of his/her Critical Illness Benefit premium? ☐ Yes ☐ No		
If "Yes", please complete the following accurately: ☐ Pre-tax ☐ Post-tax ______% paid by employer ______ % paid by employee		
Remarks:		

Fraud Notice: I have read and understand the fraud statement applicable to my state at the end of this claim form.

By signing this form, I certify that all information stated above is true.

Print name: ___________________________________ **Email Address:** _____________________________

Signature and Title: ____ **Date:** ___________________________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION B – Claimant Statement

(To be completed by Claimant. If Claimant is a minor, a parent or legal guardian must complete.)

Please check applicable Critical Illness diagnosis:

☐ Heart Attack ☐ Stroke ☐ Heart or Major Organ Transplant ☐ End Stage Renal Failure
☐ Occupational HIV ☐ Cancer ☐ Coronary Artery Bypass ☐ Alzheimer's
☐ Paralysis ☐ Blindness

Relationship to the Employee: ☐ Self ☐ Spouse ☐ Dependent

EMPLOYEE INFORMATION (complete all information):

Employee Name:	**Group Name:**	**Group Code:**	
Date of Birth: _____/_____/______	**Social Security Number:**	**Gender:** ☐ Male ☐ Female	**Marital Status:**
Employee Address (including city, state, and zip):			
Home Phone:	**Work Phone:**	**Cell Phone:**	**Fax Number:**
Email Address:			

CLAIMANT INFORMATION (if different from employee):

Claimant Name:	**Date of Birth:** _____/_____/_____	**Gender:** ☐ Male ☐ Female
Claimant Address (if different than the employee including city, state and zip):	**Social Security Number:**	
	Marital Status:	

If dependent child*: ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter Other__________________

* If dependent child is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.

Email Address (if different than the employee):	**Claimant Telephone Number:**

GENERAL INFORMATION (please answer questions for Claimant only):

1. Are you currently taking, or have you ever taken, any medication that was prescribed prior to this illness?
   ☐ Yes ☐ No If "Yes", please explain:

2. Have you ever undergone any diagnostic testing, received medical advice, sought treatment, or been given any other medical recommendation that was not completed? ☐ Yes ☐ No

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION B – Claimant Statement Continued

(To be completed by Claimant. If Claimant is a minor, a parent or legal guardian must complete.)

Employee Name:	Group Name:	Group Code:

3. Are you insured by another company for benefits related to this condition? ☐ Yes ☐ No
   If "Yes" please provide type of benefit, the amount of coverage, and if and when a claim was submitted.

4. Do you smoke or use tobacco products in any form including a nicotine patch, gum, etc? ☐ Yes ☐ No
   If "yes" please indicate amount per day and how long you have used tobacco. ______________________________
   If "no" did you ever previously use tobacco product? ☐ Yes ☐ No If "Yes", when did you quit? ____/____/____

5. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No
   If "yes" please provide date of first treatment, names, addresses, telephone and fax numbers of physicians who first treated the claimant.

6. Please provide any additional information which you think might be helpful in support of your claim.

MEDICAL CONSULTATIONS:

1. Date of critical illness event and date critical illness was diagnosed: _____/_____/_____
2. On what date did symptoms first occur? _____/_____/_____
3. On what date did you first consult a physician in connection with your illness? _____/_____/_____
4. Please provide the name and address (including city, state, and zip) of the physician consulted.
5. What test or investigation have you completed or are scheduled but have not completed? Please provide details and dates.
6. Have you previously suffered from, or received treatment for, a similar or related condition? ☐ Yes ☐ No
   If yes, please give details including dates.
7. Please provide the name, complete address (including city, state, and zip), telephone and fax numbers of your primary physician.

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION B – Claimant Statement Continued

(To be completed by Claimant. If Claimant is a minor, a parent or legal guardian must complete.)

Employee Name:	Group Name:	Group Code:

MEDICAL CONSULTATIONS:
8. Please provide details of any other doctors or specialists whom you have consulted in connection with your illness.
9. If you have been treated at a hospital or similar institution, please supply the name, address (including city, state, and zip), date of admission, and date of discharge.
10. What other treatment(s) have you received or are currently receiving in connection with your condition?

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Print name: ____

Signature of Claimant (or authorized person):______________________________ **Date**: ______________

I signed on behalf of the Claimant as ____________________________________ (indicate relationship). If authorized Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

HEART ATTACK (Myocardial Infarction)

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages if necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____
Name of Physician:	**Specialty:**	
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:

1.	a) Date of first consultation for this condition: _____/_____/______	b) How long has the insured been your patient?
2.	a) Was a diagnosis of myocardial infarction made?	
	b) Date diagnosis was made: _____/_____/______	c) Who made the diagnosis?
3.	Please provide the names and addresses of any other physicians consulted or hospitals attended by your patient, including admit and discharge dates for this heart attack.	
4.	Please provide the following details pertaining to the insured's myocardial infarction: a) ECG changes in detail at time of event (please provide copies of tracings if available).	
	b) Cardiac enzyme levels, including CPK – MB fraction and percentage of total CPK at time of diagnosis.	
5.	What other investigations have been performed? Please provide dates, complete details, and reports.	
6.	When did your patient first suffer symptoms or episodes of cardiovascular disease? Please provide details and dates.	
7.	Please provide any comments or any additional information that would be helpful in the assessment of your patient's claim.	

Please provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ____ **Date:** ___________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

STROKE / CEREBROVASCULAR ACCIDENT (CVA)

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages if necessary.)*

Employee Name:	**Group Name:**		**Group Code:**
Claimant Name:			**Date of Birth:** _____/_____/_____
Name of Physician:	**Specialty:**		
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**	
	Email Address:		

MEDICAL CONSULTATIONS:	
1.	a) On what date did the patient first consult you for this condition? _____/_____/______
	b) How long has this person been your patient?
2.	a) Was a diagnosis of Cerebrovascular Accident (CVA) made?
	b) Date the CVA occurred: _____/_____/______
	c) Please describe the cause of the CVA.
	d) Please describe the residual neurological deficits, including the dates the patient was examined for these findings.
	e) How long have the neurological deficits persisted?
	f) By whom was the diagnosis made?

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement Continued

STROKE / CEREBROVASCULAR ACCIDENT (CVA)

Employee Name:	Group Name:	Group Code:
Claimant Name:		Date of Birth: _____/_____/_____

3.	On what date was the patient advised of the diagnosis and by whom? _____/_____/_____
4.	a) Please provide the names and addresses of other physicians consulted or hospitals attended by your patient, including admit and discharge dates for this stroke or CVA.
	b) What other investigations have been performed? Please provide specific details.
5.	a) On what date did your patient first have symptoms or episodes of CVA disease? _____/_____/______
	b) What were those symptoms?
6.	Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital reports including but not limited to the CT scan or MRI if available.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ____ **Date:** ___________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

MAJOR ORGAN TRANSPLANT

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages if necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____
Name of Physician:	**Specialty:**	
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:	
1.	a) Please provide complete details of the disorder/condition leading to your patient's transplant procedure.
	b) On what date did your patient first suffer symptoms of this disorder/condition? Please list symptoms. _____/_____/_____
	c) Date the disorder/condition was first diagnosed: _____/_____/_____
	d) Date your patient was made aware of the diagnosis and by whom: _____/_____/_____
	e) How long has this person been your patient?
2.	How long has end stage disease been present with this patient?
3.	Please give details of the transplant procedure performed, including the name and address of the hospital, the attending surgeon/physician, and date of the procedure.
4.	Please provide the names and addresses of other physicians consulted or hospitals attended by your patient, including admit and discharge dates for this or any related condition.
5.	Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ____ **Date:** __________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

END STAGE RENAL FAILURE

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages if necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____

Name of Physician:	**Specialty:**	
Address (including city, state and zip)**:**	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:	
1.	a) When did your patient first consult you for renal disease? _____/_____/_____
	b) How long has this person been your patient?
2.	On what date did your patient first suffer symptoms or become aware of renal disease or impaired renal function? Please list symptoms. _____/_____/_____
3.	a) Does your patient have end stage irreversible failure of both kidneys? ☐ Yes ☐ No
	b) What is the cause of the renal failure?
	c) Date dialysis first started: _____/_____/_____ d) Is regular renal dialysis being performed?
	e) Has renal transplant taken place or is it proposed for the future?
4.	Please provide details of relevant investigations and laboratory results.
5.	Please provide the names and addresses of other physicians consulted or hospitals attended by your patient including admit and discharge dates for this or any related condition.
6.	Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ____ **Date:** ____________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

OCCUPATIONAL HIV

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages as necessary.)*

Employee Name:	Group Name:	Group Code:
Claimant Name:		Date of Birth: _____/_____/_____
Name of Physician:	Specialty:	
Address (including city, state and zip):	Phone Number:	Fax Number:
	Email Address:	

MEDICAL CONSULTATIONS:

1.	Are you the patient's usual medical attendant? ☐ Yes ☐ No	
	If yes, please provide copies of your office records, investigations performed, consultation reports, and hospitalization summaries for the past 3 years.	**If no,** please provide the full name and address of the patient's usual medical attendant.
2.	a) Date of first consultation for this condition: _____/_____/_____	b) How long had symptoms been present?
3.	Please provide the dates of all HIV or antibody tests performed and results.	
4.	Date patient was first diagnosed as HIV positive: _____/_____/_____	
5.	Please provide full details of the method of transmission, including the date and where it took place.	
6.	Was the incident reported in accordance with established occupational procedures? ☐ Yes ☐ No	
	If yes, please provide details of where this was reported. (Copies of any available reports would help with the processing of your patient's claim).	
8.	Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.	
9.	Please provide any other information which you feel would be helpful in the assessment of your patient's claim.	

Please provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ______________________________________ **Date:** ___________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

CORONARY ARTERY BYPASS SURGERY

TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS ***IMPERATIVE*** *THAT YOU ANSWER* ***ALL*** *OF THE QUESTIONS IN* ***FULL DETAIL****. (Please add additional pages as necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____
Name of Physician:	**Specialty:**	
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:		
1.	a) When did your patient first suffer symptoms or episodes of cardiovascular disease? Please list symptoms.	
	b) Date of first consult for these symptoms: _____/_____/_____	c) How long has this person been your patient?
2.	Bypass surgery details: a) Date of operation: _____/_____/_____	
	b) Which arteries were bypassed?	
	c) Name and address of the hospital and name of the operating surgeon:	
	d) Name and address of the cardiologist recommending the bypass surgery:	
3.	Please provide the names and addresses of any other physicians consulted or hospitals attended by your patient for this or any related condition. Please include admit and discharge dates.	
4.	Please provide any other information that would be helpful in the assessment of your patient's claim.	

Please provide copies of any specialist or hospital reports including the pre-operative angiography findings or a copy of the report and the operative report of bypass surgery.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ______________________________________ **Date:** ___________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

CANCER

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages as necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____

Name of Physician:	**Specialty:**	
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:

1.	a) When did your patient first suffer symptoms? Please list symptoms?	
	b) Date first consulted for this condition: _____/_____/_____	c) How long has this person been your patient?
2.	a) Date this cancer was diagnosed: _____/_____/_____	b) Date patient was advised of the diagnosis and by whom: _____/_____/_____
3.	Please provide the names and addresses of any other physicians consulted or hospitals attended by your patient (including admit and discharge dates) for this or any related condition.	
4.	Is there invasion of adjacent tissues, are regional lymph nodes involved, and/or is there distant metastasis? ☐ Yes ☐ No If yes, please provide details.	
5.	a) Has your patient previously suffered from cancer or any predisposing disorders? ☐ Yes ☐ No If so, please provide dates and details.	
	b) Has your patient ever been tested for the Human Immunodeficiency Virus? ☐ Yes ☐ No If so, please provide dates and details.	
6.	Please provide any other information that would be helpful in the assessment of your patient's claim.	

Please provide a copy of the pathology report (and any other reports as appropriate) giving the following details: Type of tumor, site of tumor, histology and staging. Also provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ______________________________ **Date:** __________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

ALZHEIMER'S DISEASE

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages as necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____

Name of Physician:	**Specialty:**	
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:

1.	a) When did your patient first suffer symptoms? Please list symptoms.	
	b) Date first consulted for this condition: _____/_____/_____	c) How long has this person been your patient?
2.	Please outline the clinical course and briefly describe the patient's signs and symptoms. Provide dates and durations.	
3.	Date the diagnosis of possible Alzheimer's disease was first discussed with the patient: _____/_____/_____	
4.	What tests have been performed to rule out other dementing organic brain disorders and psychiatric illnesses?	
5.	Please provide the names and addresses of any other physicians consulted or hospitals attended by your patient (including admit and discharge dates) for this condition.	
6.	Name, address and phone number of the specialist who confirmed the diagnosis.	
7.	Please provide any other information that would be helpful in the assessment of your patient's claim.	

Please provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ________________________________ **Date:** __________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

BLINDNESS

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages as necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____

Name of Physician:	**Specialty:**	
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:

1.	a) Date first consulted for any eye problems: _____/_____/_____	b) How long has this person been your patient?
2.	Date patient first suffered symptoms or became aware of any eye problems (provide date and details):	
3.	a) What is the corrected vision or field of vision in each eye?	
	b) Date test performed: _____/_____/_____	
	c) Please provide the name, address and phone number of the ophthalmologist.	
4.	What is the cause of the blindness?	
	Is the blindness permanent? ☐ Yes ☐ No	
	Is there any treatment that could improve your patient's vision? ☐ Yes ☐ No	
5.	Please give the names and addresses of any other physicians consulted or hospitals attended by your patient for this vision loss or any related eye disorder including dates.	
6.	Please provide any other information that would be helpful in the assessment of your patient's claim.	

Please provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ________________________________ **Date:** ___________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

SECTION C – Attending Physician Statement (To be completed and signed by the physician.)

PARALYSIS

*TO ALLOW US TO MAKE AN ASSESSMENT OF YOUR PATIENT'S CLAIM IT IS **IMPERATIVE** THAT YOU ANSWER **ALL** OF THE QUESTIONS IN **FULL DETAIL**. (Please add additional pages as necessary.)*

Employee Name:	**Group Name:**	**Group Code:**
Claimant Name:		**Date of Birth:** _____/_____/_____
Name of Physician:	**Specialty:**	
Address (including city, state and zip):	**Phone Number:**	**Fax Number:**
	Email Address:	

MEDICAL CONSULTATIONS:	
1.	Please provide a brief outline of the medical history leading to your patient's paralysis.
2.	Date first consulted for this condition (provide date and details): _____/_____/_____
3.	If paralysis was not a result of an accident, when did your patient first suffer symptoms or become aware of this condition?
4.	a) Which limbs are affected?
	b) Provide details of exact loss of function.
	c) What is the residual use, if any, of affected limbs?
	d) State the underlying cause of this condition.
5.	Are there any treatments that could improve the paralysis? ☐ Yes ☐ No
6.	Is the condition permanent without **ANY** likelihood of improvement? ☐ Yes ☐ No
7.	Please provide results of all relevant investigations.
8.	Please give the names and addresses of any other physicians consulted or hospitals attended by your patient (including admit and discharge dates) for this condition.

Please provide copies of any specialist or hospital reports.

FRAUD NOTICE: I have read and understand the fraud statement applicable to my state at the end of this claim form.

Signature of physician: ____ **Date:** ___________

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

Authorization to Release Information

Patient Name:	Date of Birth:
Address:	Social Security Number:

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the injured or deceased's occupation, finances and health including protected health information, individually identifiable health information, summary health information, mental health, **HIV/AIDS*,** and alcohol/drug records to release all such records in their entirety *excluding psychotherapy notes* to AlwaysCare Benefits, Inc., and its representatives (collectively and severally, the "Company").

I understand that the Company will use the information obtained by this authorization for the purposes of evaluating and administering claims for benefits or as may be lawfully required or permitted, or as I may further authorize.

I understand that I may receive a copy of this authorization, and that this authorization is valid for two years or as limited by state requirements, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand revocation or failure to sign this authorization may impair the ability of AlwaysCare Benefits, Inc., and its representatives to evaluate my claim and, as a result, may be a basis for denying my claim.

A photographic or electronic copy of this authorization is as valid as the original.

I understand that information disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal or state rules governing privacy and confidentiality of health information.

Name of person signing this form:	Telephone Number:
Mailing Address (including city, state and zip):	

In what capacity are you signing this form? (Note: if other than the Employee/Patient or Surviving Spouse of the Employee/Patient for whom information is to be released, please attach appropriate documentation substantiating your authority.)

Print name: ___________________________________

Signature: ___________________________________ **Date:** ___________________________

* If you reside in **California:** This authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

* If you reside **in Connecticut, Maine or Massachusetts**: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). Separate authorizations signed by the insured claimant, or employee-claimant (for self insured business) are required each time results are released.

*If you reside in **Vermont:** This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING AlwaysCare Benefits, Inc., or its representatives to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and AlwaysCare Benefits, Inc., and its representatives shall comply, as applicable, with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

AlwaysCare

Telephone: 1-888-729-5433, Ext. 2013
Fax: 1-888-843-5872
Email: CIClaims@AlwaysCareBenefits.com

NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

FRAUD STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

For residents of all states *EXCEPT* Arizona, Arkansas, California, Colorado, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, New York, Tennessee, Virginia, Washington and the District of Columbia:

"Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud." AlwaysCare Benefits, Inc. shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of 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 residents of 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."

FOR RESIDENTS OF 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."**

For residents of Colorado:

"It is unlawful to knowingly provide false, incomplete, or misleading 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 an settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies."

For residents of the 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 were provided by the applicant."

For residents of 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 residents of Kansas:

"Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of committing a fraudulent insurance act."

For residents of Kentucky:

"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."

For residents of 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."

For residents of 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 residents of 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."

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NOTICE OF CLAIM FOR CRITICAL ILLNESS INSURANCE

For residents of 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."

For residents of New Jersey:
"Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

For residents of 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."

For residents of 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."

For residents of 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 residents of 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"

For residents of 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 a person to criminal and civil penalties."

For residents of Puerto Rico:
"Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years."

For residents of Rhode Island:
"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."

For residents of Tennessee:
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage."

For residents of Virginia:
"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."

For residents of Washington:
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.