Administrator's Office
PO Box 25326
Overland Park, KS 66225-5326
1-800-237-4463

Important:

What you need to know about filing your claim

You can avoid any unnecessary processing delays by making sure you provide all of the following:

1. The Completed Patient's Statement claim form. This must be filled out completely, signed and dated.

2. The HIPPA authorization form. This needs to be signed and dated so we can contact your medical provider on your behalf if additional information is required for claim consideration.

3. Please provide any medical diagnostic testing you've had done. This applies only to specific illness policies and specific illness riders.

4. If your policy provides benefits for provider services, please provide the itemized provider bills. Standard billing forms include CMS-1500 and UB-04. Your provider of service should be able to provide these forms for you. **Balance due statements from the provider or explanation of benefits statements from other insurance carriers do NOT contain enough information for claims processing and will NOT be accepted.**

5. On a hospital bill, please make sure the statement indicates:
   A. Date of Admission
   B. Date Discharged
   C. The number of Room and Board days being charged.

Return the completed claim form, the signed and dated HIPPA authorization and any itemized bills to:

Administrative Office
PO BOX 25326
Overland Park, KS 66225

We suggest you make photocopies of any correspondence sent to our office to keep for your records.

Patient's Statement

Please note it is important that all questions be answered fully and this form be returned to the company. If the patient is a minor the questions should be answered by the parent or guardian.

1. Policy Number(s):_____

2. Patient's Name:_____

3. Address:_____

4. Phone number:_____

5. Insured's Name (if other than patient):_____

6. Date of Birth: _____

7. Date patient became ill or date of accident:_____

8. Date patient first saw any doctor for this condition:_____

9. Have you ever had this condition before:____Yes ____No

   If yes, date:_____

10. Doctors Name:_____

    Doctors Address:_____

11. Did this condition result in hospital confinement?____Yes ____No

    If yes, please list dates:_____

12. Do you have any other hospital and or medical insurance (including Medicare and Medicaid): ____Yes ____No If Yes, policy number:_____

    Name and address of other insurance:_____

    _____

Authorization: I understand this information will be used by the Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent the answers to the above questions are complete, true and correct, to the best of my knowledge and belief.

_____ _____

Signature of patient or authorized representative Date signed

HIPAA AUTHORIZATION

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

Name of proposed Insured/Patient _____ Date of Birth _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire record and any other projected health information concerning me to the company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the company may: I) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the company at P.O. Box 25326, Overland Park, Kansas 66225-5326, Attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I received a copy of this authorization.

Signature of proposed Insured/Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Patient _____

Important Claim Notice - FRAUD WARNINGS

ALL STATES EXCEPT AS INDICATED BELOW

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 may be a crime and may subject such person to criminal and civil penalties.

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.

ARIZONA

For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, LOUISIANA, AND 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.

CALIFORNIA

For your protection California Law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

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.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO

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

INDIANA

Any 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.

KANSAS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

KENTUCKY, OHIO, AND PENNSYLVANIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

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 denial of insurance benefits.

MARYLAND

ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MINNESOTA

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

NEW HAMPSHIRE

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

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

NEW YORK

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

OKLAHOMA

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

OREGON

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information may thereby commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

TENNESSEE, VIRGINIA, 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.

VERMONT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 may be a crime and may subject such person to criminal and civil penalties.