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 HIPAA 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; and
   c) The number of Room and Board days being charged.

Return the completed claim *form,* the signed and dated HIPAA 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.

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

Policy Number(s):_______________ Insured's Name:_______________

Patients Name (if other than Insured):_______________ Date of Birth: _______________

Claim is being made for the following Condition(s): please circle and provide information as listed

- CANCER - Type of Cancer: _______________ Date 1st Diagnosed:_______________
- HEART ATTACK
- STROKE
- ACCIDENT - Describe how, when, and where accident occurred: _______________
  ____
- SICKNESS / OTHER - Please provide description or diagnosis: _______________

Date patient first saw any physician for condition(s) listed above: _______________

List treating physicians seen for condition(s) claimed: please use back if more space needed.

Physician Name / Address:_______________

Physician Name / Address:_______________

Physician Name / Address:_______________

List all hospital confinements for the condition(s) claimed: please use back if more space needed.

Hospital Name / Address:_______________ Dates of confinement_______________

Hospital Name / Address:_______________ Dates of confinement_______________

Hospital Name / Address:_______________ Dates of confinement_______________

Does patient have any other medical insurance (including Medicare and Medicaid)? ____Yes ____No

If Yes, list Policy Number, Name / 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

CLAIM FRAUD WARNING

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.

Alabama, Arkansas, District Of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files 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.

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.

Delaware, Idaho, Indiana, 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.

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

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.

Maine, 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 may include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or 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.

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

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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.

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P.O. Box 25326
Overland Park, KS 66225-5326
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AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION

This authorization must be written, dated, and signed by the Policyholder or by a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original (unless applicable state law provides otherwise).

I, or my authorized representative, hereby 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, to disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records, as described below. I understand these records may contain information created by other persons or entities, including health care providers as well as information recording the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (Note: psychotherapy notes may be used/disclosed only pursuant to a separate authorization pertaining only to psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.

Patient Name:____Patient Date of Birth:____

Policy Number(s):____

1. Persons/entities authorized to receive the information:____
2. Type of information the insurer is authorized to use or disclose:
   - ☐ Entire Medical Record, including patient histories, office notes (excluding psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to Unified Life Insurance Company by health care professionals, insurers, other such health care providers.
   - ☐ Other:____
3. The information will be used or disclosed for the following purposes:____
4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my enrollment in the health plan, eligibility to receive benefits, ability to obtain treatment, or ability to receive payment for treatment, unless allowed by law. If I refuse to release my complete medical record, the insurer may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.
5. I understand that I may revoke this authorization at any time by notifying the insurer in writing at: P.O. Box 25326, Overland Park, KS 66225-5326, Attention: Compliance Manager; except to the extent that:
   a. We have taken action in reliance on this authorization; or
   b. If authorization was obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
6. This authorization shall remain in force for thirty (30) months following the date of my signature below or unless otherwise stated below:
   This authorization expires [on] [upon]_______________________[date] or is valid until_____________________________[event].
7. The insurer will not receive compensation from a third party for using or disclosing this information.

I understand that once health information about me has been disclosed by the insurer to a third party, the health information may no longer be protected by federal privacy laws. All items on this form have been completed and my questions about this form have been answered. In addition, I have kept a copy of this form for my records.

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 as directed above.

______________________________	______________________________
Printed name of Policyholder or Authorized Representative	Relationship to Policyholder and authority to act for Policyholder
______________________________	______________________________
Signature of Policyholder or Authorized Representative	Date