Colonial Life Universal Claim Form

Fax this direction	Fax this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia SC 29202	From:	
		Number of pages:	

Optional Service Release Agreement

Please indicate below for optional services. Any marks used (check mark, X and initials) will be considered as authorization and will be processed.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the individual inquiring on my behalf. **Leave blank if you do not want anyone accessing your claim information.**

_____ Sales representative _____ Employer _____ Spouse, family member or significant other Name: _____

_____ I want Colonial Life to update me on the status of my claim through electronic messaging at my home phone number indicated on this form. I understand messages will be left with anyone who answers the phone or on my answering machine. To avoid blocked calls, I should program the number 1-800-325-4368 into my phone.

_____ **Yes, I want ALL payment(s) for this claim sent by overnight delivery.** I understand payment(s) under $100.00 cannot be sent overnight. If you wish your claim payment to be sent by overnight delivery, a **$22.00 fee,** which is subject to rate increases by carrier and does not include weekend delivery, will be deducted from my claim payment(s). **I understand that Colonial Life is unable to overnight mail to a P.O. Box, and I must notify Colonial Life in writing to discontinue this service.**

Additional Information

Wellness/health screenings

If you wish to file a wellness/cancer screening claim for a test performed within the past 18 months, you'll need to submit the type and date of the test performed, as well as your physician's name and phone number. We also need to know if this is for you or another covered individual. If this is for another covered individual, we need his or her name and Social Security number. If you file by telephone or Internet, please retain a copy of the medical information and/or, your receipt if needed for further verification.

You may file by:

- **Phone:** Call 1-800-325-4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week; or
- **Internet:** Use the Wellness Claim Form at ColonialLife.com; or
- **Fax/Mail:** 1-800-880-9325 / P.O. Box 100195, Columbia SC 29202 Write your name, address, Social Security number and/or policy/certificate number on your bill and indicate "Wellness Test."

If your wellness/cancer screening test was more than 18 months ago, you must fax or mail us a copy of the bill or statement from your physician indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, Social Security number and current address on the bill.

Please complete each section entirely before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim.

Checklist

- ☐ Social Security number of claimant
- ☐ If your name has changed, attach a copy of your marriage certificate or driver's license
- ☐ Sign and date "Authorization" page of form
- ☐ Signature and date for each section (physician and/or employer must sign their sections)
- ☐ If filing for Accident:
  Attach itemized copies of any related bills
- ☐ If filing for Disability:
  Section 4 must be fully completed by your physician, including diagnosis, treatment and unable to work dates. Section 5 must be completed by your employer. Include a copy of the hospital bill(s) showing admission and discharge dates, daily room charge(s) and medical expenses incurred. Include copy of the anesthesia bill if outpatient surgery was performed.

Special instructions

All dates should be written in month/day/year format (e.g. 12/14/1980). Social Security number is indicated by SSN.

Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others require the following statement to appear on this claim form. **Fraud Warning:** Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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, Rhode Island, Texas and West Virginia: For your protection, California, Rhode Island, Texas and West Virginia law requires the following to appear on this form: Any person who knowingly presents 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: 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.

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.

Kentucky: For your protection, Kentucky law requires the following to appear on this form: 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 a 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 or 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 Jersey and New Mexico: 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 such violation.

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 such person to criminal and civil penalties

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present; it may be reduced to a minimum of two (2) years.

Please check the type of claim you are filing below:

☐ Accident ☐ Disability ☐ Routine pregnancy ☐ Wellness ☐ Hospital confinement /outpatient surgery

Section 1 (completed by policy owner)

Claimant name:			Relationship to policy owner: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic partner
☐ Male ☐ Female	Claimant DOB: _____ / _____ / _____	Claimant SSN:	
Policy owner name:		DOB: _____/ _____/ _____	SSN:
Mailing address:	City:	State:	ZIP:
Home telephone:	Work telephone:	Policy owner's email:	
Primary physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Referring physician or hospital:	Telephone:	Fax:	
Address:	City:	State:	ZIP:

Section 2 – Accidental injury (completed by policy owner)

Please complete and attach itemized copies of any related bills, including physician, ambulance, emergency room, hospital, and/or rehabilitation unit. Bills should include diagnosis information from your medical provider.

Date the accident occurred (not when it was treated): _____ / _____ / _____ | Accident occurred: ☐ On-job ☐ Off-job

Have you been treated for the same or similar condition prior to this occurrence? ☐ Yes ☐ No If yes, when: _____ / _____ / _____

Hospital admission: ☐ Yes ☐ No

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Description of how the accident occurred (if auto accident, attach a copy of the accident report):

Certification

Policy owner's name: _____ SSN: _____

I have checked the answers on this claim form, and they are correct. I certify under penalty of perjury that my correct Social Security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page two of this form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. **Fraud Warning:** 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.

Claimant's name	Claimant's signature	Date
Policy owner's name	Policy owner's signature	Date

Claimant name:	**Claimant SSN:**

Section 3 – Hospital confinement/hospital intensive care unit confinement benefits (completed by physician)

Refer to your certificate for required proof of loss requirements. Ask your physician to complete the following section. Include a copy of the hospital bill(s) showing the admission and discharge dates, the daily room charge(s) and the medical expenses incurred. Please send a copy of the anesthesia bill if outpatient surgery was performed.

Hospital:			Telephone:
Address:	City:	State:	ZIP:
Admitting physician:			Telephone:
Address:	City:	State:	ZIP:

Hospital confinement:

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Was anesthesia administered? ☐ Yes ☐ No

Was anesthesia administered by a licensed anesthesiologist? ☐ Yes ☐ No

Is condition due to an accidental injury? ☐ Yes ☐ No

Intensive care unit confinement:

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Rehabilitation unit:

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Surgery/inpatient:

Admission: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Procedure description/Procedure code:

Admitting diagnosis/ICD-9 codes:

Secondary diagnosis/ICD-9 codes:

Physician office visit(s) following outpatient surgery:

1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____ 4. _____ / _____ / _____

If hospital confinement is for pregnancy or pregnancy complications, provide the following:

Estimated date of conception: _____ / _____ / _____

Date first treated: _____ / _____ / _____

Date of delivery: _____ / _____ / _____

Type of delivery: ☐ Vaginal ☐ C-section

Procedure code:

Treating physician:			Telephone:
Address:	City:	State:	ZIP:

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

_____

Signature of physician completing this form

_____

Date (MM/DD/YYYY)

Tax ID or SSN:	Telephone:	Fax:

Claimant name:	**Claimant SSN:**

Section 4 – Disability (completed by physician)

Patient name:	DOB:

What primary condition prevents the patient from working?

Symptoms:	Objective findings:

Date first treated for this condition: _____/_____/_____	Is condition due to an accidental injury? ☐ Yes ☐ No	If yes, date and description of accidental injury:
If pregnancy, estimated date of delivery: _____/_____/_____		

Secondary conditions preventing the patient from working? ☐ Yes ☐ No	Secondary conditions:

Current treatment plan:

List all dates patient received: medical advice, diagnosis or treatment for this condition (or a related condition) for the 18 months prior to this disability to the present. (please list dates: MM/DD/YYYY)

When did symptoms first appear? _____/_____/_____	Date of new patient consultation: _____/_____/_____	Date of patient's last visit: _____/_____/_____

Following were performed: ☐ Test(s) ☐ Surgery (Submit copy of test results/operative report.) Date and procedure code for any surgeries:	Limitations (patient CANNOT DO):	Restrictions (patient SHOULD NOT DO):

How soon do you expect significant improvement in the patient's medical condition? ☐ 1 - 2 months ☐ 3 - 4 months ☐ 5 - 6 months ☐ more than 6 months

Expected return to work: _____ /_____ /_____	Dates unable to work (full-time): From: _____/_____/_____ To: _____/_____/_____
Date released to return to work: _____ /_____ /_____	Dates unable to work (part-time): From: _____/_____/_____ To: _____/_____/_____
Does patient have permanent restrictions/limitations? ☐ Yes ☐ No	If not employed, dates of house confinement: From: _____/_____/_____ To: _____/_____/_____ House confinement means the patient is kept at home (in house or yard) by the condition. However, the patient may follow your orders, even if it means leaving home.

Check activities of daily living that the patient is unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Toileting ☐ Continence ☐ Bathing ☐ Transferring

Date(s) of office visit (last 6 months):	How often do you see the patient?
Date(s) of hospitalization (last 6 months):	Have you referred patient for other types of consultations? ☐ Yes ☐ No

Hospital:			Specialist:		
Address:	State:	ZIP:	Address:	State:	ZIP:

Fraud warning: **Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.**

_____ Physician signature	_____ Date (MM/DD/YYYY)

Physician/group name:	Patient account number:

Physician's specialty:	Telephone:	Fax:
Address:	State:	ZIP:

Tax ID or SSN:	Do you accept medical records request by Fax? ☐ Yes ☐ No
Was patient referred to you by another physician? ☐ Yes ☐ No	Do you have authorization on file to release information to Colonial Life? ☐ Yes ☐ No

Claimant name:	**Claimant SSN:**

Section 5 – Disability (completed by employer)

Employee name:	Title:	Hire date: _____ / _____ / _____
Average number of scheduled hours per week:	Last worked: _____ / _____ / _____	Employment terminated: _____ / _____ / _____
Employee unable to work (full-time): From: _____/ _____/ _____ To: _____/ _____/ _____		Sick leave was exhausted on: _____ / _____ / _____
Approved for FMLA (if eligible): From: _____/ _____/ _____ To: _____/ _____/ _____		Employee at work when accident or sickness occurred? ☐ Yes ☐ No
Workers' compensation claim filed? ☐ Yes ☐ No	Workers' compensation carrier:	Telephone:
Hourly employee rate:	Hours worked per week:	Annual salary:	Include commissions: attach commission breakdown for prior 12 months from date last worked.
Do you permit light or partial duty for employee?		
Expected return: _____ / _____ / _____	Returned to work: Full-time: _____ / _____ / _____	Part-time: _____ / _____ / _____ Hours per week:

Employee's duties include:	☐ Sitting _____ per hr. ☐ Walking _____ per hr. ☐ Climbing stairs/ladders _____ per hr.	Contact for updates on return to work status
	☐ Standing _____per hr. ☐ Lifting: ☐ Less than 15 lbs. ☐ 15 to 44 lbs. ☐ More than 45 lbs.	Name:
Stooping/bending: ☐ none ☐ seldom ☐ frequent	Reaching/pulling/pushing: ☐ none ☐ seldom ☐ frequent	Telephone:
Crawling/kneeling: ☐ none ☐ seldom ☐ frequent	Repetitive motion: ☐ none ☐ seldom ☐ frequent	Email:

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes attending physician portions of the claim form.

_____ Employer signature	_____ Date (MM/DD/YYYY)
Print name:	Title:

Telephone:	Fax:	Email:

Authorization for Colonial Life & Accident Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non-health information, including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms, may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not re-disclose the information unless permitted or required by those laws. Re-disclosed information may no longer be protected by federal privacy laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier, and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P.O. Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim.

I am the individual to whom this authorization applies or that person's legal guardian, power of attorney designee, conservator, beneficiary or personal representative.

_____ XXX-XX-_____ _____

Signature | Last four digits of SSN | Date of birth

_____ _____

Printed name of individual subject to this disclosure | Date signed

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative.

_____ _____ _____

Printed name of legal representative | Signature of legal representative | Date signed