CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

CANCER CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.
To prevent delays, please provide documentation from your healthcare provider to support this claim.
Please review your policy for specific benefits covered under your plan.

- ✓ **Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.**
- ✓ **If this claim is for an individual covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.**

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

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

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

Policyholder's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

POLICYHOLDER/PATIENT INFORMATION

EMPLOYER'S NAME			POLICYHOLDER'S EMAIL ADDRESS	
POLICYHOLDER'S NAME	POLICY NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER
POLICYHOLDER'S ADDRESS	CITY / STATE / ZIP CODE		POLICYHOLDER'S TELEPHONE NO.	
☐ CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE.				
PATIENT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	PATIENT'S DATE OF BIRTH	PATIENT'S DATE OF DEATH (IF APPLICABLE)	
WHAT DATE WAS THE CANCER FIRST DIAGNOSED BY A PATHOLOGIST? (ATTACH A COPY OF THE PATHOLOGY REPORT)		HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION: ☐ YES ☐ NO		
LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIANS FOR THE CANCER (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)				
IF THE CANCER REQUIRED HOSPITALIZATION, PROVIDE THE NAME AND ADDRESS OF THE TREATING FACILITY (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)				

Please sign the attached HIPAA form and return it with the completed claim form.

- Please be sure to include the following information along with this claim form:
  - Positive pathology report
  - Itemized bills from facility or provider including diagnosis and/or procedure codes and charge amounts (Itemized bills may include but are not limited to the following claim forms: UB04, HCFA1500, etc.)
- If filing for the Lump Sum Cancer Plan, please submit a copy of the patient's birth certificate.
- Transportation/Lodging Information: To be completed if you are filing a claim for transportation or lodging: (please submit the hotel receipts and mileage information) **For additional information, please refer to your policy language.*

Date	To/From	Round-trip Mileage	Type of Treatment

CANCER CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT			
PATIENT'S NAME		DATE OF BIRTH	DATE OF DEATH (IF APPLICABLE)
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? ☐ YES, WHEN_____. ☐ NO	DIAGNOSIS (INCLUDING COMPLICATIONS)	

- Has the patient been diagnosed with cancer? ☐ No ☐ Yes (If yes, please submit the initial pathology report or exam that diagnosed cancer)
- Type of cancer: _____
- Date of initial diagnosis: _____
- First date of treatment for this diagnosis: _____
- Please provide the name, address and phone number of the patient's primary treating physician.
  Name: _____ Phone Number: _____

  Address: _____

- Was the patient treated by any other physicians? ☐ No ☐ Yes
  If yes, physician's name(s):_____ Phone Number(s):_____

  Address: _____

- Was the patient confined to the hospital as a result of this diagnosis? ☐ No ☐ Yes (Please submit the itemized hospital bill, UB04, or HCFA 1500)
  Admission date _____ Discharge Date _____

  Hospital name_____

  City _____ State _____
- Did the patient undergo surgery for this condition? ☐ No ☐ Yes (If yes, please submit a copy of the operative report or surgeon's bill to include charges.)
  Where was the surgery performed? ☐ Office ☐ Surgical Center ☐ Outpatient Hospital ☐ Inpatient Hospital
  Name of facility: _____

  Address: _____

- Has the patient received chemotherapy? ☐ No ☐ Yes (If yes, please submit a copy of itemized billing.)
  Name of facility where chemotherapy was received: _____

  Address: _____
- Has the patient received oral chemotherapy? ☐ No ☐ Yes (If yes, please submit pharmaceutical statements.)

- Has the patient received topical chemotherapy (Treatment with anticancer drugs in a lotion or cream applied to the skin)? ☐ No ☐ Yes (If yes, please submit pharmaceutical statements.)

- Has the patient received radiation therapy? ☐ No ☐ Yes (If yes, please submit a copy of itemized billing.)
  Name of facility where radiation was received: _____

  Address: _____

ATTENDING PHYSICIAN'S SIGNATURE			
I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.			
NAME (ATTENDING PHYSICIAN) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIPCODE
SIGNATURE	DATE	MEDICAL ID#	

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents 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.

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: 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 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: 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.

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.

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: A 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, 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 may be guilty of insurance fraud as determined by a court of law.

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.

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.

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.

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.

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

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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 such violation.

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.

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.

OREGON: 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 may be guilty of insurance fraud.

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 dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should 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.

TENNESSEE: 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.

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.

VIRGINIA: 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.

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.

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.

ALL OTHER STATES: 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.

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INSURED_____ POLICY NUMBER_____

AUTHORIZATION TO OBTAIN INFORMATION
CONTINENTAL AMERICAN 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 for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history 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 any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or 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. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC 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 I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization 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.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____ _____
(Printed Name of Individual Subject to Disclosure) (Date of Birth)

_____ _____
(Signature) (Date Signed)

If applicable, I signed on behalf of the insured as _____.
(Indicate relationship, legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.)

_____
(Printed Name of Legal Representative)

_____ _____
(Signature of Legal Representative) (Date Signed)