# 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:		

## **File Your Claim Online**

- ▶ Simply log into your account at Coloniallife.com and click on "File an Online Claim".
- ▶ As an added convenience, you may also select Direct Deposit when filing online.
- ▶ Not a member? Log onto Coloniallife.com and click on "Register" then "Join the Policyholder Website" to set up your account.

# **Optional Service Release Agreement**

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the following individual(s) inquiring on my behalf.

Note: 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 prerecorded messages at my contact number indicated on this form. I understand that messages will be left with anyone who answers the phone or on my answering machine. Note: To avoid blocked calls, you should program the number 1-800-325-4368 into your 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. I also understand that if I want my claim to be sent by overnight delivery, a \$22.00 fee will be deducted from my claim payment. This fee is subject to rate increases by carrier, includes delivery only on business days and does not include weekend or holiday delivery. I understand that Colonial Life is unable to send overnight mail to a P.O. Box. Save time and money, and choose Direct Deposit by filing your claim online.

Yes, I want to Direct Deposit all payments into my bank account. I have enclosed a voided check for a checking account or a deposit slip for a savings account with my initial claim submission. Please note: Allow up to three business days after claim payment for deposit into your account.

I also understand that I must notify Colonial Life to discontinue any of these services.

### **Additional Information**

#### Wellness/health screenings

If you wish to file a wellness/cancer screening claim for a test performed within the past 36 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:

- Internet: File your claim online at Coloniallife.com or
- **Phone:** 1-800-325-4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week; 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 36 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.

#### Checklist

- □ Provide Social Security number of claimant.
   □ If your name has changed, attach a copy of legal documentation.
   □ Sign and date "Authorization" page.
- ☐ Include signature and date for each section (physician and/or employer must sign their sections).
- ☐ Dates should be written in month/day/year format (e.g. 12/14/1980).

## Use this form when filing under more than one policy.

Complete each section entirely before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim. Please make sure that all written responses are legible.

- Benefits are payable to you unless we receive written authorization to pay benefits elsewhere. This is called an assignment.
- If this claim is for an individual covered by 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.

## Complete the sections that apply to your coverage.

- ☐ **If filing for accident:** Attach itemized copies of any related bills.
- ☐ If filing for cancer: Attach a copy of the pathology report along with all itemized bills related to the condition.
- ☐ If filing for critical illness: Attach all medical information related to the illness. (See Critical Illness claim form for medical information required.)
- ☐ If filing for disability: Section 3 must be completed by your employer.

  Section 5 must be fully completed by your physician, including diagnosis, treatment and unable to work dates. 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.
- ☐ If filing for hospital or rehabilitation confinement: Submit a copy of the itemized bill showing admission and discharge dates and the daily room charges. If itemized bill is not available, have your physician complete 4A.
- ☐ If filing for surgery or diagnostic procedure: Submit a copy of the itemized surgeon's bill showing the diagnostic/procedure codes and a copy of the operative report. If the itemized bill is not available, have your physician complete 4B.

# **Claim Fraud Statements**

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming 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.

**California:** 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:** 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.

**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 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.

Colonial Life & Accident Insurance Company | UNIVERSAL CLAIM FORM | Fax: 1-800-880-9325 | Telephone: 1-800-325-4368 Please check the type of claim you are filing below: ☐ Accident ☐ Cancer ☐ Critical illness ☐ Disability ☐ Routine pregnancy ☐ Hospital confinement / outpatient surgery Section 1 - Claimant statement (completed by policy owner) Relationship to policy owner: Claimant name: ☐ Self ☐ Spouse ☐ Dependent Claimant DOB: ☐ Male ☐ Female □ Domestic partner Claimant SSN: SSN: Policy owner's name: DOB: City: 7IP: Mailing address: Apt.# State: Home telephone: Work telephone: Policy owner's email: Primary physician: Telephone: Fax: State: ZIP: Address: Referring physician or hospital: Telephone: Address: 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. Accident occurred: ☐ On-job ☐ Off-job Date the accident occurred (not when it was treated): \_\_\_\_\_/ \_\_\_\_\_ (If on-job injury, attach copy of Report of Injury document) Emergency room treatment only: 

Yes 

No If yes, date of emergency room treatment \_\_\_\_\_/ \_\_\_\_/ \_\_\_\_\_ **Hospital admission:**  $\square$  Yes  $\square$  No Description of how the accident occurred (if auto accident, attach a copy of the police report if available.): Certification \_\_\_\_\_ SSN: \_\_\_\_ Policy owner's name: \_\_\_ 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: For your protection, Arizona law requires the following to appear on this claim form: Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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. Fraud Warning: For your protection, New York law requires the following to appear on this claim form: Any person who knowingly and with the 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. Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes the Physician Statement portion of the claim form.

Claimant's signature

Policy owner's signature

Date (MM/DD/YYYY)

Date (MM/DD/YYYY)

Print claimant's name

Print policy owner's name

Claimant na	me:								Claima	nt SSN:		
Section	3 - Employers	stateme	ent (c	ompleted by em	ploye	er)						
Employee name									SS	SN:		
Employee title:									Hi	re date:	/	
Average numbe	r of scheduled hours per v	veek:	1	Date last worked:	/_	/_		Date e				/
Employee unab	le to work (Full-time): Froi	m:/.	/.	To:	_/	_/		Sick le	ave was ex	hausted	d on:/_	/
Approved for FN	/ILA (if eligible): From:	/	/	To:/	_/		Was empl	oyee at	work when	acciden	it or sickness occu	rred?
	ensation claim filed?			kers' compensation ca					Te	elephone	·:	
Hourly employe	e rate:	Hours wor		-	Annu	al salary:				If paid	l on commission bas	sis, attach commission ths from date last worked.
Do you permit l	ight duty for employee?	⊥ ]Yes □ N	0			Do you	permit part	tial duty			Yes 🗆 No	
Expected return	to work:	A	ctual ret	urn to work:				Ac	tual return	to work:		
/									Hours per week:			
Employee's duties Sitting per hr.  Ualking per hr.  Climbing stairs/ladders per hr.  Standing per hr.  Driving hrs. per day												
include: Lifting:   Less than 15 lbs.   15 to 44 lbs.   More than 45 lbs.   Stooping/bending:   none   seldom   frequent												
Reaching/pulli	ng/pushing: □ none □	] seldom $\square$	] frequent	t Crawling/kneelin	ıg: 🗆	none $\square$	seldom $\square$	frequen	t Repeti	tive mot	ion: none none	seldom 🗆 frequent
Contact for upd	ates on return to work sta	tus:							Teleph	none:		
Email:									Fax:			
Frau	<b>d warning:</b> Any pe cri			ngly files a state penalties. This ir								n is subject to
			Signature	e of authorized person							Date (N	MM/DD/YYYY)
Title of authorized	d person:					Employ	/er/company	/ name:				
Telephone:		Fa	ax:				Email:					
Section	<b>4A -</b> Hospital	confine	ement	t/rehabilitat	ion c	confin	ement	(com	pleted b	y phys	ician)	
	Please submit the follow	-					-		_		•	ım charges.
		are unable	to provi	ide billing statement	ts, plea	ase have		-				
Diagnosis/ICD	codes:						Diagn	ostic pi	ocedure d	ate:	Diagnostic prod	cedure code/description:
								/	/	T	-	
Hospital:						0:4				Telepl		710.
Address: Admitting phys	ioloni					City:					State: Dhone:	ZIP:
Address:	ician:					City:				<del></del>	State:	ZIP:
	ioni					City.						ZIF.
Address:	idii.					City:				<u> </u>	ohone: State:	ZIP:
	nfinement and/or 🗆 Ob	econyation Po				City.				`	state.	ZIF.
			Time:		PM	Date rele	ased:	/_	/_		Time:	
Intensive care	unit confinement:											
Admission date	://_		Time:		PM	Date rele	ased:	/_	/_		Time:	
Rehabilitation	unit confinement:											
Admission date	::/		Time:		PM	Date rele	ased:	/_	/_		Time:	$\_$ $\square$ am $\square$ PM

Claimant name:					Claimar	nt SSN:	
Section 4/	A – Hospital confine	ment/rehabilitation c	onfinement	– continu	ed (c	ompleted by phy	/sician)
DDECNANOV	If complications due to	Date first treated for pregnancy:	Date of	delivery:	Туре	of delivery: 🗌 Vagi	inal   C-section
PREGNANCY	pregnancy, complete section 5.	/	/	/	Surg	ical procedure code:	
Fraud w	varning: Any person who k criminal and civi	nowingly files a statement penalties. This includes at					n is subject to
	Signature of ph	nysician completing this form				Date (MM/D	D/YYY)
Physician name:				Patient accoun	nt numbe	er:	
Address:			City:			State:	ZIP:
Tax ID or SSN:			Telephone:			Fax:	
Will you accept the	standard HIPAA release?	□ No	Do you accept med	lical record requ	uests by f	ax? 🗆 Yes 🗆 No	
Do you require a sp	ecial authorization for release of inf	formation?	Authorization on fil	e to release info	ormation 1	to Colonial Life: 🔲	Yes □ No
Section 4	<b>3</b> - Surgery/Diagnos	stic Procedure (comple	eted by physicia	n)			
Please sul	omit the following with your claim: If you are unable t	a copy of the itemized surgeon's o provide billing statements, plea					e operative report.
Surgery:   Inpati	ent 🗆 Outpatient		Surgery procedur	e description/	code(s):		
Admission:	/ / Tir	me:					
Released:	_ / / Time	e:					
Anesthesia adminis	stered? 🗆 Yes 🗆 No 📗 Anesthes	sia administered by a licensed anes	thesiologist? $\square$ Yes	s 🗆 No 🛮 Is	s conditio	n due to an accident	al injury? □ Yes □ No
Physician office vi	sit(s) following surgery:			<u>'</u>			
1/	/	// 3	//	<u> </u>	4	//	
Diagnosis/ICD co	des:		Diagnostic proced	dures:			
			Date: /	/		Code:	
			Date: /	/		Code:	
Fraud w	varning: Any person who k	nowingly files a statement penalties. This includes at					n is subject to
	Signature of pl	nysician completing this form				Date (MM/D	D/YYYY)
Physician name:				Patient accou	nt numbe	er:	
Address:			City:			State:	ZIP:
Tax ID or SSN:			Telephone:			Fax:	
Will you accept the	standard HIPAA release?	□No	Do you accept med	lical record requ	uests by f	ax? 🗆 Yes 🗆 No	
Do you require a sp	ecial authorization for release of inf	formation?	Authorization on fil	e to release info	ormation t	to Colonial Life: 🔲 '	Yes 🗆 No

Claimant name:							CI	aimant	SSN:				
Section 5 - Physician	State	ment (co	mpleted by	physic	cian	1)							
Patient name:										DO	DB: / _		/
Is condition due to an accidental injury?	 □ Yes □	□ No			If y	es: Date and	descript	ion of ac	cidental ii				
Was x-ray taken? ☐ Yes ☐ No Date of			/										
What primary diagnosis prevents the pati				nplication	ns. If i	routine pregna	ncv. comi	olete infor	mation be	low.)	Date first trea	ated fo	or this condition:
			-6										_/
Are there any secondary diagnoses prever				□ No	Se	condary diag	noses:						
		ew patient con		Sympto	oms:								
Current treatment plan:	/	<u>//_</u>											
List all dates patient received: medical a	advica d	liagnosis or tra	atment for this	condition	on								
(or a related condition) for the 18 month		-			011	(List dates: N	1M/DD/Y	YYY)					
List any test performed (submit copy of t	est result	s)				List any surg	eries pe	rformed	(submit c	opy of operat	tive report)		
Date://	CP	T code:				Date:	/	/		CPT c	ode:		
Date://	CP	T code:				Date:	/	/		CPT c	ode:		
		e of next scheo					-						edical condition?
//		_							4 montns NNOT DO				than 6 months SHOULD NOT DO):
Does patient have permanent restrictions If yes, which ones are permanent:	s and/or	limitations? L	⊔ Yes ∟ No			Lillia	ations (p	atient GA	INNOT DO	). Re	Strictions (pa	atient	SHOULD NOT DO).
		/ /	To:		,	/			Evnoete	d roturn to v	vork:		/
Dates unable to work (full-time): From:  Dates able to work (part-time):		//_	10	/		/			Expecte	u return to v	VOIK	_/	/
From: / To: _	/_	/	Numbe	er of hour	rs wo	orked:			Actual r	eturn to wor	k:/		/
Did this condition require house confinement?    Yes    No If yes, dates: From://    To://    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 par	tient is u	nable to perfo	rm: Dressir	ıg 🗆 E	ating	g $\square$ Meal pi	eparatio	n 🗆 Ba	thing [	Transferrin	g 🗆 Toileti	ng [	Continence
Dates unable to perform activities of daily	living: F	rom:	/ /		To:	/	/						
Dates unable to perform activities of daily living: From: / To: / To: / Date(s) of hospitalization (last 6 months):  Date(s) of office visit (last 6 months):													
How often do you see the patient?  Have you referred patient to a specialist?   Yes   No													
Hospital: Sp						st:							
Address:				Add	dress	;:							
City:		State:	ZIP:	City	/:						State:		ZIP:
Telephone:	Fax:			Tele	phor	ne:				Fax:			
PREGNANCY		ed date of deli	ivery:	/								/	
Type of delivery: ☐ Vaginal ☐ C-section			ate of delivery:	/							_/		
Fraud warning: Any per						· · · · · · · · · · · · · · · · · · ·	taining	r falco		<u> </u>		ic cı	phicat to
		_	iy illes a sta ies. This incl				•	-		_		15 51	ibject to
O.IIIIII		orri portare				,	ororan <sub> </sub>	po		0.0			
		Physician sig	 gnature								ate (MM/DD	/YYYY	)
Physician/group name:		,	5					Patien	t account		,	,,	<u>'</u>
Physician's specialty:						Telephone:				FAX:			
Address:				City						State:		ZIP:	
Tax ID or SSN:						accept medic	al record	roquocte	hy fay?		No		
Do you require a special authorization for	rologog	of information	2 □ Voc □ N			*		1				2002	□Voc □ No
Was patient referred to you by another ph					Patient Portal								169
Referring physician:	., c.o.a	00 _ 1			phor			Fax:					
Address:				City	-					State:		ZIP:	
Tax ID or SSN:				3.09									

# **Authorization for Colonial Life & Accident Insurance Company**

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

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 and its duly authorized representatives (Colonial Life).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. Some information, once 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 or as authorized by me.

I also authorize Colonial Life to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Colonial Life; or, the Social Security Administration. Colonial Life will not condition the payment of insurance benefits on whether I authorize Colonial Life to re-disclose my information. For the purposes of these disclosures by Colonial Life, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), 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. 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 I do not sign this authorization or if I alter or revoke it, except as specified above, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

Signature	Date signe	Date signed (MM/DD/YYYY)						
	XXX-XX-							
Printed name of individual subject to this disclosure	Last four digits of SSN	Date of birth (MM/DD/YYYY)						
f applicable, I signed on behalf of the insured as power of attorney designee, conservator, beneficiary or person	•	elationship). If legal guardian, document granting authority						
one of account, according to the contract of t								

