Fax to: Claims 1.800.880.9325
From:_____
Number of pages: _____
Or Mail to: P.O. Box 100195
Columbia SC 29202-3195

Catastrophic Accident

Fax this direction.

Colonial Life.
Making benefits count.

Please be sure to send the following Information:

- ✓ Do not file before the 365 day elimination period for this benefit has been met
- ✓ Signed and dated authorization

OPTIONAL SERVICE RELEASE AGREEMENT – Please **initial** below for optional services. Any other marks used (check mark, x, etc.) will not be considered as authorization and will be processed as blank.
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 _____ plan administrator
_____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. Messages will be left with anyone that 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 and an $18.00 fee, which is subject to rate increases by carrier and **does not include weekend delivery,** will be deducted from my claim payment(s). **We are unable to overnight mail to a P.O. Box and you must notify us in writing to discontinue this service.**

If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)

Section 1	**To be completed by Policy owner**	
Claimant name __Male __Female	**Birth Date**	**Claimant Social Security Number**
Relationship to Policy Owner: ___ spouse ___ dependent ___self ____domestic partner		
Policy owner (First, Last)	**Birth Date**	**Social Security Number**
Mailing Address (Street or PO Box)		**Apartment number**
(City) (State) (Zip)		**Home telephone**
Policy owner e-mail address		**Work Telephone**

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.

Arizona Residents : 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 Residents : 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 Residents : 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 and Maryland Residents : 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 Residents : 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 Residents : 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.

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 Residents : 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 Residents : 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.

Oregon Residents : Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Puerto Rico Residents : 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.

CERTIFICATION

Policy owner's Name_____ **Social Security #**_____

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 2 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.**

Please remember to also sign and date the attached authorization required to process your claim.

X_____	X_____	X_____
Claimant's Signature	Policy owner's Signature	Date (MM/DD/YYYY)

The following sections to Be Completed by Physician			
Patient's Name	**Patient's Date of Birth**		
Referring Doctor's Name:		**Phone Number : ( )**	
Referring Doctors Address: (Street)	**(City)**	**(State)**	**(Zip Code)**
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 Employer and Attending Physician portions of the claim form.			
Doctor's Signature (completing this form):		**Date :_____ (MM/DD/YYYY)**	
Tax ID or SSN :	**Phone Numbers: ( )**	**Fax Number: ( )**	
Was the loss the result of an accidental injury? ____Yes ____No **If Yes, provide the date and Description of the Accident: Date :_____ (MM/DD/YYYY)**			
Are there any underlying health factors that contributed to this loss? ____Yes ____No **If yes, please specify these health factors :**			
To what extent are these health factors affecting this patient's condition?			

Please answer all questions:
Please check all statements that describe this patient's condition.

Has the patient sustained a total and irrecoverable :

Fax this direction.

____ Loss of both hands or both feet; or,

____ Loss of both arms or both legs; or,

____ Loss of one hand and one foot; or,

____ Loss of use one arm and one leg (The loss of use of an arm means the loss of function of the entire arm from the Shoulder to the hand. The loss of use of a leg means the loss of function of the entire leg from the hip to the foot);or,

____ Loss of the sight of both eyes(The loss of sight means both eyes are totally blind and that no sight can be Restored); or,

____ Loss of the hearing of both ears (The loss of hearing means deafness in both ears, such that it cannot be corrected To any functional degree by any procedure, aid or device); or,

____ Loss of the ability to speak (The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device).

Has the insured regained partial or complete use of any of the above since the date of the accident?
____Yes ____No

If yes, please indicate the date and explain their current status. Date :_____
(MM/DD/YYYY)

Do you expect the patient to regain or complete use of any of the above? ____Yes ____No

If yes, when do you expect improvement?

Please provide the names, addresses and telephone numbers of all other physicians who have treated this patient for this loss.

Doctors Name	Phone number	Address
1.		
2.		
3.		
4.		
5.		
6.		

Please provide all medical records for this patient related to the Accident

____ Check here if medical records are attached

____ Check here if you will be sending medical records under separate cover and the date we may expect them. Date : _____
(MM/DD/YYYY)

____ Check here if you require a fee for the records. If you accept payment by VISA, or if you require Prepayment, please call us at 1.800.325.4368. Otherwise, please bill our office.

Note : Please make a copy of the patient's signed authorization to release information for your records

Please mail completed claim form and medical records to:

Colonial Life & Accident Insurance Company
Claims Department
PO Box 100195
Columbia, SC 29202-3195

Fax this direction.

OR

Fax to : 1.800.880.9325

Phone 1.800.325.4368 Fax 1.800.880.9325

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 disclose the information unless permitted or required by those 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.

X_____ XXX-XX-_____ _____

(Signature) (Social Security Number — last 4 digits) (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)