



CRITICAL ILLNESS CLAIM FORM

Provident Life and Accident Insurance Company
 The Benefits Center, P.O. Box 100158, Columbia, SC 29202-3158
 Pacific Time Zone Toll-free: 1.877.851.7637 Fax: 1.877.851.7624
 All Other Time Zones Toll-free: 1.800.858.6843 Fax: 1.800.447.2498

SECTION A

| Policyholder Information | | | | Patient Information <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self | | | |
|----------------------------|--|--|---------------------------------|--|--|--|---------------------------------|
| Policy Number(s) | | | | | | | |
| Name (First, Middle, Last) | | | <input type="checkbox"/> Male | Name (First, Middle, Last) | | | <input type="checkbox"/> Male |
| | | | <input type="checkbox"/> Female | | | | <input type="checkbox"/> Female |
| Address (Street) | | <input type="checkbox"/> Check here if NEW address | Apt # | Address (Street) | | <input type="checkbox"/> Check here if NEW address | Apt # |
| City | | State | Zip Code | City | | State | Zip Code |
| Social Security Number | | Date of Birth | | Social Security Number | | Date of Birth | |
| | | __ / __ / ____ | | | | __ / __ / ____ | |
| Home Phone Number | | Work Phone Number ext. | | Home Phone Number | | Work Phone Number ext. | |
| () | | () | | () | | () | |

SECTION B

| | | | | | | | |
|--|--|------------|----------|---|--|------------|----------|
| What type of illness are you claiming? | | | | When were you first treated for this illness? (Date mm/dd/yyyy) | | | |
| | | | | __ / __ / ____ | | | |
| Primary Doctor Name | | | | Treating Doctor Name | | | |
| Address (Street) | | | | Address (Street) | | | |
| City | | State | Zip Code | City | | State | Zip Code |
| Phone Number | | Fax Number | | Phone Number | | Fax Number | |
| () | | () | | () | | () | |

Note: Please include a list of all physicians/facilities from which you have received treatment for this condition within the last ten years. You may attach a separate piece of paper for this information.

HOSPITAL INFORMATION (If ever hospitalized or seen at the hospital for this condition)

| | | | | | | | |
|-----------------------------------|--|-------|----------|-----------------------------------|--|-------|----------|
| Hospital Name | | | | Hospital Name | | | |
| Address | | | | Address | | | |
| City | | State | Zip Code | City | | State | Zip Code |
| Hospital Phone Number | | | | Hospital Phone Number | | | |
| Date Seen/Admitted __ / __ / ____ | | | | Date Seen/Admitted __ / __ / ____ | | | |
| Date Discharged __ / __ / ____ | | | | Date Discharged __ / __ / ____ | | | |

Signature of Claimant _____ Please Print Name _____

The statements made by me on this claim are true and complete.

Date Signed _____ Social Security Number _____

I signed on behalf of the claimant, as _____ (indicate relationship). **If Power of Attorney, Guardian, or Conservator, please attach a copy of the document granting authority.**

CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear:

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.

Fraud Warning for California Residents

For your protection, California law requires the following to appear:

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.

Fraud Warning for 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.

Fraud Warning for District of Columbia, Maine, Tennessee and Virginia Residents

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

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

Fraud Statement for New Jersey, New Mexico and 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.

Fraud Statement for New York Residents

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 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.

ATTENDING PHYSICIAN'S STATEMENT - CRITICAL ILLNESS

PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION

| | | |
|---|---|--|
| 1. Patient's Name (First, middle initial, last name) | 2. Patient's Birthdate ____ / ____ / ____ | 3. Patient's Address (street, city, state, zip code) |
| 4. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | 5. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child | |
| 6. Patient's or Authorized Person's Signature (I authorize the release of any medical information necessary to process this claim). | | |

Signed _____ Date _____

PHYSICIAN OR SUPPLIER STATEMENT (if filing for Health Screening Benefit only, please answer only questions #10 and #17)

| | | | |
|--|--|--|---|
| 7. Date of Illness (first symptom) OR Injury (accident) | 8. Date first consulted you for this condition | 9. Has patient previously had same or similar condition: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, show first treatment date(s) | 10. PLEASE CHECK TESTS CONDUCTED FOR THE PATIENT HEALTH TESTING <input type="checkbox"/> Blood Test for Triglycerides <input type="checkbox"/> Bone Marrow Aspiration/Biopsy <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> CA 15-3 (Blood Test for Breast Cancer) <input type="checkbox"/> CA 125 (Blood Test for Ovarian Cancer) <input type="checkbox"/> CEA (Blood Test for Colon Cancer) <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Fasting Blood Glucose Test <input type="checkbox"/> Fasting Plasma Glucose (FPG) <input type="checkbox"/> Two Hour Post-Load Plasma Glucose (2 Hour PG) <input type="checkbox"/> Hemoglobin A1C (HbA1c) <input type="checkbox"/> Flexible Sigmoidoscopy <input type="checkbox"/> Hemocult Stool Analysis <input type="checkbox"/> Mammography <input type="checkbox"/> Pap Smear <input type="checkbox"/> PSA (Blood Test for Prostate Cancer) <input type="checkbox"/> Serum Cholesterol Test to Determine Level of HDL and LDL <input type="checkbox"/> Serum Protein Test to Determine Level of HDL and LDL <input type="checkbox"/> Skin Cancer Biopsy <input type="checkbox"/> Stress Test on Bicycle or Treadmill <input type="checkbox"/> Thermography <input type="checkbox"/> Thin Prep Pap Test <input type="checkbox"/> Other |
| 11. Name of referring or other treating physicians | | 12. For services related to hospitalization give hospitalization dates Admit: _____ Disch: _____ | |
| 13. Name and address of facility where services rendered (if other than home or office) | | | |
| 14. Diagnosis or nature of illness or injury, relate diagnosis to procedure by reference in Column D to Numbers 1, 2, 3, etc. or DX code. Note: if possible please give CPT-4 procedure code in the "C" below and ICD-9 in "D". | | | |
| 1. _____ | | | |
| 2. _____ | | | |
| 3. _____ | | | |
| 4. _____ | | | |

| 15. A Date of Service | B* Place of Service | C Procedure Code (Identify:) | Fully describe procedures, medical services or supplies furnished for each date given (Explain unusual services or circumstances) | D Diagnosis Code | E Charges |
|--------------------------|------------------------|----------------------------------|---|---------------------|--------------|
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| | | | | | |
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| | |
|---|---|
| 17. Medical Providers Signature and Medical Specialty | 16. Total Charge |
| Signed _____ Medical Specialty _____ Date _____ | 18. Your Social Security Number or Taxpayer I.D. Number (required by law) |
| 19. Your Patient's Account Number | |

20. Please provide the test results, operative reports, pathology reports, and/or your detailed medical statement for the claimed condition below:

| | |
|---|---|
| Condition Cancer Carcinoma in situ Coronary Artery Bypass Surgery End Stage Renal Failure Heart Attack Major Organ Transplant Stroke Permanent Paralysis | Medical Documentation Pathology Report Pathology Report and/or Clinical Diagnosis Open heart surgical report Regular hemodialysis and/or Peritoneal dialysis Any of the following: Electrocardiograph (EKG), Cardiac enzymes, Thallium scans, MUGA scans, Stress echocardiogram Surgical Reports Documented neurological deficits and/or Neuroimaging studies Clinical Diagnosis |
|---|---|

*Place of Service Codes

| | | |
|-------------------------------|-----------------------------|---|
| 11-Office | 26-Military Facility | 51-Inpatient Psychiatric Facility |
| 12-Home | 31-Skilled Nursing Facility | 52-Psychiatric Facility Partial Hospitalization |
| 21-Inpatient Hospital | 32-Nursing Facility | 53-Community mental Health Center |
| 22-Outpatient Hospital | 33-Custodial Care Facility | 54-Intermediate Care Facility/Mentally Retarded |
| 23-Emergency Room/Hospital | 34-Hospice | 55-Residential Substance Abuse Treatment Facility |
| 24-Ambulatory Surgical Center | 41-Ambulance (Land) | 56-Psychiatric Residential Treatment Center |
| 25-Birthing Center | 42-Ambulance (Air or Water) | 61-Comprehensive Inpatient Rehabilitation Facility |
| | | 62-Comprehensive Outpatient Rehabilitation Facility |
| | | 65-End Stage Renal Disease Treatment Facility |
| | | 71-State or Local Public Health Clinic |
| | | 72-Rural Health Clinic |
| | | 81-Independent Laboratory |
| | | 99-Other Unlisted Facility |

VB-378 (1/05)



NOTE: Federal law requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, UnumProvident may not be able to evaluate or administer your claim(s). Please sign and return this authorization to: Customer Care, 1 Fountain Square, Chattanooga, TN 37402.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; government organization; and employer (and any of its agents performing services relating to employee benefits or workers compensation) that has information about my health, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer claims for UnumProvident Corporation, Provident Life and Accident Insurance Company, and duly authorized representatives ("UnumProvident"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information UnumProvident obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for benefits. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent UnumProvident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to: Customer Care, 1 Fountain Square, Chattanooga, TN 37402.

I understand if I do not sign this authorization or if I alter its content in any way, UnumProvident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

(Applicant Signature)

(Date Signed)

(Print Name)

(Social Security Number)

I signed on behalf of the claimant as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.