

# The Standard®

Standard Insurance Company 866.851.5505 Tel 402.328.4029 Fax PO Box 85508 Lincoln NE 68501-5508

# **Health Maintenance Screening Benefit Claim Form**

Group Policy No.

#### **Instructions**

Full Name

Please complete, sign and submit this form to the address or fax number stated at the top of this form. You will need to complete a separate form for each family member.

For specific information about your benefits, refer to your group insurance certificate. The group policy and certificate are the ultimate authority for Health Maintenance Screening Benefit claim decisions. If you need additional information, please contact your employer's benefit administrator or call the customer service line listed above.

Employer/Company Name

For a prompt review of your claim, ALL of this form must be thoroughly completed and signed.

# A. About the Insured

| Date of Birth  Sex Male   |  |  | ☐ Fei  | male         |              |  |
|---------------------------|--|--|--|--------------|--------------|--|
| Email Address             |  |  |  |              |              |  |
|                           |  |  |  |              |              |  |
| Ci                        | City   |  |  | State        |              | ZIP  |
|                           |  |  |  |              |              |  |
|                           |  |  | ] Civil I  | Union Part   | tner 🗌       | Child  |
| So                        | Social Security No.  |  |  | Phone No.    |              |  |
|                           |  |  |  | (            | )            |  |
|                           |  | Date of Birth  |  |              | Sex          | Male Female  |
| Screening Proc            | cedure   | e(s) performed   |  |              |              |  |
| Date Performed (mm/dd/yy) |  | ocedure  |  |              |              | Date Performed (mm/dd/yy)  |
|                           | Co   | mprehensive Metab  | oolic Pa   | nel (CM      | P)           |  |
|                           | Ele  | Electrocardiogram (EKG)  |  |              |              |  |
|                           | He   | Hemocult stool analysis  |  |              |              |  |
|                           | He   | Hemoglobin A1C   |  |              |              |  |
|                           | Hu   | Human Papillomavirus Vaccination (HPV)   |  |              |              |  |
|                           | Lip  | Lipid panel  |  |              |              |  |
|                           | Ma   | Mammography  |  |              |              |  |
|                           | Pap  | Pap smears or thin prep pap test   |  |              |              |  |
|                           | PS   | PSA (blood test for prostate cancer)   |  |              |              |  |
|                           | Str  | Stress test (bicycle or treadmill)   |  |              |              |  |
|                           |  | Generally medically accepted cancer screening test*  |  |              |              |  |
|                           | You Spouse not need to complete Screening Procedure Performe | City  You Spouse Do not need to complete this Social Security  Coreening Procedure  Date Performed (mm/dd/yy)  Co  Ele  He  He  Hu  Lip  Ma  Pap  PS.  Str.  Ge: | City  You Spouse Domestic Partner Dot need to complete this section again.  Social Security No.  Date of Birth  Coreening Procedure(s) performed  (mm/dd/yy) Procedure  Comprehensive Metable Electrocardiogram (Electrocardiogram (Electrocardio | City     You | City   State | Sex   Male   Ference   F |

### D. Acknowledgement

I certify that the above statements are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 2 of this form.

| Signature of Insured | Ι | Date |
|----------------------|---|------|
| -                    |   |      |

<sup>\*</sup>Procedure is only available in the state of California.

# Health Maintenance Screening Benefit Claim Form Fraud Notices

Some states require us to provide the following information to you:

#### ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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.

#### CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: 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.

#### 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 the 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 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 an 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

# **NEW JERSEY RESIDENTS**

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 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.

# ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.