Critical Illness Claim Form

ManhattanLife™

Insured Statement

Is the claimant the: ☐ Policyholder ☐ Dependent

Policyholder's name:_____Policy No._____
(If this is a name change, provide a copy of an updated driver's license, government issued ID, marriage license or divorce decree.)

Date of Birth_____Mailing Address_____

City_____State_____ ZIP Code_____ Phone No._____

Claimant Name_____Date of Birth_____

Type of Critical Illness for which the claim is being made:
Refer to your policy certificate to determine which benefits are available under your policy.

Critical Illness/Condition	Childhood Condition
☐ Coronary Artery Bypass ☐ Coronary Heart Disease ☐ Heart Attack ☐ Heart Transplant ☐ Sudden Cardiac Arrest ☐ Brain Aneurysm ☐ Stroke	☐ Cerebral Palsy ☐ Cleft Lip and/or Cleft Palate ☐ Cystic Fibrosis ☐ Down Syndrome ☐ Spina Bifida ☐ Type 1 Diabetes
☐ Transient Ischemic Attack	**Infectious Disease**
☐ Benign Brain Tumor ☐ Coma ☐ End Stage Renal Disease ☐ Loss of Vision, Hearing or Speech ☐ Major Organ Failure ☐ Major Organ Transplant ☐ Occupational Hepatitis or HIV ☐ Permanent Paralysis ☐ Severe Burns ☐ Bone Marrow or Stem Cell Transplant	☐ Cerebrospinal Meningitis ☐ Malaria ☐ Encephalitis ☐ Legionnaire's Disease ☐ Necrotizing Fasciitis ☐ Osteomyelitis ☐ Tuberculosis
	Progressive Disease
☐ Invasive Cancer ☐ Malignant Melanoma ☐ Non – Invasive Cancer ☐ Skin Cancer	☐ ALS (Lou Gehrig's Disease) ☐ Multiple Sclerosis ☐ Advanced Dementia (including Alzheimer's) ☐ Advanced Parkinson's

Any person, who with the intent to defraud or knowing they are facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and for insurance fraud. (See State specific fraud warnings statements on page 8).

The above statements are true to the best of my knowledge and belief.

_____ _____ _____

Signature of Policyholder *Printed Name* *Date*

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Please review the information below to ensure complete and accurate documents are submitted along with the claim form. **The below benefits do not apply to all critical illness policies, review your Policy Certificate for specific benefit eligibility.**

1. If the insured was transported via **ambulance** (air or ground) as a result of their covered illness, submit the itemized ambulance bill.

2. If the insured was **confined to a hospital** as an inpatient, as a result of their covered illness, submit the itemized hospital statement (UB04).

3. If the insured is filing for any of the below **travel expenses**, include travel receipts with the claim form submission.
   - **Lodging for the insured**
   - **Lodging for a family member**
   - **Transportation**

4. If the insured receives a **second opinion or consult** from a second physician for the diagnosis or treatment of their critical illness, submit the itemized physician statement (HCFA1500).

5. If the insured receives a **vaccine** for the prevention of cancer: Humana Papillomavirus (HPV) or Hepatitis B virus (HBV) submit proof of the inoculation.

Physician Information

Attending Physician and/or Facility:

Physician or Facility Name	Phone No.	Address

Has the claimant ever been treated for the same or similar condition in the past? ☐ Yes ☐ No
If yes, provide the prior treating physician information below.

Physician or Facility Name	Phone No.	Address

Has the claimant every been hospitalized for this condition? ☐ Yes ☐ No
If yes, provide the facility information below.

Facility Name	Phone No.	Address

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Review the conditions listed below. Enclose the requested documentation listed within the Requested Documentation section for the condition the claimant is being treated for. **All diagnosis must occur after the policy effective date. The below benefits do not apply to all critical illness policies, review your Policy Certificate for specific benefit eligibility.**

Illness/Condition	Medical Documentation Requirements
Heart Attack	• Medical records from the emergency room and cardiologist • EKG report(s) • Cardiac enzymes levels • Imaging studies • Echo cardiogram(s)
Heart Transplant	• Medical records from the transplant team • Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human-to-human replacement of thewhole heart
Coronary Heart Disease	• Diagnosis of coronary heart disease made by angiography test(s) in which the recommended treatment plan includes a CABG.
Coronary Artery Bypass Surgery	• Diagnosis of coronary heart disease made by angiography test(s) in which the recommended treatment plan includes a CABG.
Sudden Cardiac Arrest	• Medical records from the emergency room and cardiologist
Brain Aneurysm	• Computed Tomography (CT) Scan • CT Angiography (CTA) • Cerebrospinal fluid test • Magnetic resonance imaging (MRI) • MRI and angiography MRA
Stroke	• Medical records from the neurologist • Neuroimaging report(s) • Modified Rankin Scale results 90 days after stroke
Transient Ischemic Attack (TIA)	• Medical records from treating physician
Invasive Cancer Malignant Melanoma Non-Invasive Cancer Skin Cancer	• Pathologist's report
Benign Brain Tumor	• Pathologist's report • Magnetic resonance imaging (MRI) • Magnetic Resonance Spectroscopy (MRS) • Computed Tomography (CT) Scan
Coma	• Medical records from neurologist • Proof of complete and continuous unconsciousness state not less than 24-96 hours in duration which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes
End Stage Renal Failure	• Medical records from the nephrologist • Proof of renal dialysis

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Illness/Condition	Medical Documentation Requirements
Loss of Vision	• Medical records from ophthalmologist; including refractions, visual acuity, and visual field • Proof must document that the blindness was due to Accidental Injury or Sickness; and that the condition has continued without interruption for a period of at least six (6)consecutive months after diagnosis.
Loss of Speech	• Medical records from a neurologist • Clinically-proven that the loss of ability to speak has continued without interruption for a period of at least six (6) consecutive months
Loss of Hearing	• Medical records from an audiologist • Proof of irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months after diagnosis
Major Organ Failure	• Medical records • Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing organ
Major Organ Transplant	• Medical records • Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing organ
Occupational Hepatitis or HIV	• Medical records • Proof that the cause of HIV must be from an Accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the 12 months preceding diagnosis; accident occurred while covered person was following the normal occupational duties and reported in accordance with the established occupational procedure for such accidents; the covered person must have undergone a blood test within 5 days of the accident which indicate the absence of HIB or antibodies to such a virus; within 12 months of the accident, the covered person must undergo a follow up blood test indicating the presence of HIV or antibodies to such a virus
Permanent Paralysis	• Medical records • Proof that loss is expected to be permanent; been present continuously for at least180 days; caused by injury sustained in an accident; evidenced by the total and irreversible loss of use of two or more limbs; marked by loss of muscle function in two arms, two legs, or one arm and one leg
Severe Burns	• Medical records from plastic surgeon • Proof that covered person has sustained third degree burns covering at least 20% ofthe surface area of their body
Bone Marrow or Stem Cell Transplant	• Medical records from plastic surgeon • Proof that covered person has sustained third degree burns covering at least 20% ofthe surface area of their body
Childhood Condition Cerebral Palsy Cleft Lip/Cleft Palate Cystic Fibrosis Down Syndrome Spina Bifida	• Medical records from treating physician

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Illness/Condition	Medical Documentation Requirements
Progressive Disease ALS (Lou Gehrig's) Multiple Sclerosis Advanced Dementia (including Alzheimer's) Advanced Parkinson's	• Medical records from treating physician
Infectious Disease Cerebrospinal Meningitis Encephalitis Legionnaire's Disease Malaria Necrotizing Fasciities Ostemyelitis Tuberculosis	• Medical records from treating physician

If the claim is being filed for services within the first 2 years following the policy effective date, complete the physician and medical request below.

Physician information: *List all of the physicians the claimant was treated by in the 5 years prior to the policy effective date.*

Physician or Facility Name	Address	Phone No.	Reason for Visit

Medication information: *List all medications being taken by the claimant.*

Medication	Prescribing Physician	Date Prescribed

Direct Deposit Authorization

ManhattanLife™

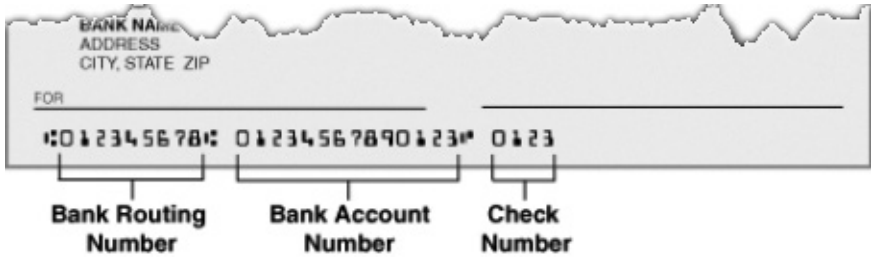
Check Action			Account Type		Ownership of Account	
☐	☐	☐	☐	☐	☐	☐
New	Change	Cancel	Checking	Savings	Self	Other

Policy Holder's Name_____ Policy Number_____

Bank Name_____

Bank Routing Number_____ Bank Account Number_____

Account Holder's Name _____



Terms and Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program, please read the following terms and conditions for participation carefully before making your decision. Not all polices may qualify.

1. Once the Form is received by ManhattanLife, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify ManhattanLife of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be canceled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to ManhattanLife or cannot be made to your account, ManhattanLife will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be canceled by your financial institution or ManhattanLife. **Your participation will be canceled automatically if you terminate participation in the above Account(s).**

I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize ManhattanLife to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Signature _____ Printed Name _____ Date _____

Mail to: ManhattanLife VB Claims
PO Box 926169
Houston TX 77292

Customer Care: 1-855-448-6982
Fax: 1-502-405-7107
Email: vbclaimssubmissions@manhattanlife.com

Authorization to Release Information
For the Use and Disclosure of Protected Health Information

Patient's Name_____**Policy No.** _____

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals to disclose my protected health information to ManhattanLife
3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
5. I authorize only designated staff of ManhattanLife to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Attn: Claims Department PO Box 926169 Houston, TX 77292 . This revocation shall become effective on the date it is received by ManhattanLife. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

_____ _____ _____
Signature *Printed Name* *Date*

I have legal authority* under the laws of the State of_____to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies and execute this Authorization in my capacity as Authorized Representative thereof.

_____ _____ _____
Name of Authorized Representative/Parent or Guardian *Relationship to Applicant* *Date*

**A copy of the legal authority document must be on file with ManhattanLife.*

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ManhattanLife

Treating Physician Statement

Patient Information

Patient Name_____ Policy No._____

Date of Birth_____ Address_____

City_____ State_____ ZIP Code_____

Treatment Information

Diagnosis (include any complications)_____

ICD -9/ICD – 10 Code(s)_____

Date the symptoms first appeared:_____ Date of first visit:_____

Date of definitive diagnosis:_____ Date of surgery(CABG):_____

Has the patient been treated for this same or a similar condition prior to this occurrence? ☐ Yes ☐ No
If yes, list the date(s) of prior treatment_____

Was this patient referred to you? ☐ Yes ☐ No
If yes, provide the referring physician information below:

Referring Physician Name_____ Phone No._____
Referring Physician Address_____

Any Person, who with the intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 8)

The above Statements are true to the best of my knowledge and belief.

Printed name of Treating Physician_____ Phone No._____

Specialty_____ Street Address_____

City_____ State_____ ZIP Code_____

_____ _____

Signature of Treating Physician Date

Claim Form Addendum: Fraud Warning and State Versions

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 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. **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. **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. **California** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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 of claim 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. **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. **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. **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 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. **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 by 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 be 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. **Rhode Island** 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. **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. **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.