

# Claim Form and Instructions

**Fax to: Claims 1.800.880.9325**

From: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Date: \_\_\_\_\_

Number of pages: \_\_\_\_\_

Your disability claim must be filed within  
12 months of your date of loss.

**What can I do to avoid delays?**

**Missing information will delay the processing of your claim. Please be sure you:**

- Sign** and return the attached Certification on page 3 and authorization on page 7.
- Complete** the sections that apply to your specific claim. Please have your **doctor and employer** complete their sections, if applicable.
- Enclose** copies of all **bills** connected with your claim, if applicable.

**When should I expect a reply?**

- If you are filing a claim for a sickness or health condition occurring within the first 6 to 24 months of your policy/ certificate (based on policy requirements), we need to determine if the condition is **pre-existing**. We may have to write for this information which may delay your claim. **Please include the signed authorization with your claim and ask your doctor to promptly respond to our request for medical information.**

We will call you to advise when your claim information is in processing. Mail time is a large contributor to the time it takes for our response to reach you. **Mail** may take up to four or five days each way.

**To avoid mail delays:**

- **Fax** your claim to us at **1.800.880.9325**. If you are faxing your claim, please make a copy of the back pages and fax all pages of the claim together. **Please do not mail the original document but keep it for your records.** Please allow **at least two business days** for our automated service center to be updated with information confirming receipt of your fax. You will receive an automated call when your fax has been updated in our system.
- Have your payment returned by **overnight delivery** by initialing the Service Release below. A \$18.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments of \$100.00 or more. A street address is required. Your check will be delivered Monday through Friday; however, the time is not guaranteed.**

**OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below as indicated.**

I authorize The Paul Revere Life Insurance Company to facilitate processing this claim by releasing its details if he/ she is inquiring on my behalf.

\_\_\_\_ local sales representative \_\_\_\_\_ plan administrator \_\_\_\_\_ spouse, family member or significant other  
 (initial) (initial) (initial)

\_\_\_\_ I authorize The Paul Revere Life Insurance Company to communicate information on the status of this  
 (initial) claim through **electronic messaging** at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/answering machine. I will program phone number 1.800.325.4368 into my phone to avoid calls being blocked.

\_\_\_\_ Yes, please deduct the \$18.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from  
 (initial) my claim payment for this claim. This fee does not include weekend delivery. I understand this fee will be deducted for **future payments** for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under \$100.00 will be sent by regular mail.

Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying The Paul Revere Life Insurance Company in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by The Paul Revere Life Insurance Company.

- Benefits are payable to you unless we receive a written authorization from your provider to assign benefits to them. This is called an **assignment**. If you wish to assign your benefits, please attach a signed written request.
- 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.

**CLAIMANT NAME:** X **SOCIAL SECURITY NUMBER:** \_\_\_\_\_

Mail to: The Paul Revere Life Insurance Company  
Processing Center  
PO Box 100195  
Columbia SC 29202-3195

Fax to: 1.800.880.9325

If you fax your claim, do not mail the original document but keep it for your records.

**Your claim must be filed within 12 months of your date of loss.**

Please **check** the type of claim you are filing below:

- Wellness-** See top of page 3.
- Specified Disease for Cancer Policy-** See below.
- Routine Pregnancy-** See page below if you are filing for benefits for normal post-delivery disability. Pages 4 and 5 are not necessary.
- Total Disability-** (Accident/Sickness/Pregnancy complications) Section B contains parts for both your employer and doctor to complete. See pages 4 and 5.
- Accidental Injury-** Section C, page 5, requests specific information from you about the circumstances of your injury.
- Hospital Confinement or Outpatient Surgery-** Have your doctor complete Section D, page 6, and send copies of your hospital or outpatient surgery bills.

If you have any questions while completing this claim form, please call us at 1-800-325-4368. We will assist you with the information and forms needed.

### SPECIFIED DISEASE FOR CANCER

If you do not have a cancer policy, please complete the sections that apply to your coverage. To file for benefits under a cancer policy, please complete page 3 and check **specified disease for cancer** at the top of this page:

- For *Internal Cancer* – Attach a copy of the **pathology report** from your *initial* diagnosis.
- Attach copies of itemized statements for all medical expenses incurred relating to the diagnosis and treatment of your malignancy. Please clearly write your name and social security number on each bill.
- For *Skin Cancer* – Attach a copy of your pathology report for *each date of service* a lesion was biopsied and/or removed.
- *Transportation and Lodging* – Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.
- **If you are claiming disability, please have your employer and doctor complete SECTION B.**

To be completed and signed by your doctor

**A. ROUTINE PREGNANCY (6 weeks for vaginal delivery or 8 weeks for c-section, less the elimination period)**

**If disabled due to complications of pregnancy, before or after delivery, complete Section B on page 4.**

Date of Delivery (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Type delivery: Vaginal / C-Section (circle one)

Date you first treated patient for this pregnancy (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of Hospital Confinement (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Hospital: \_\_\_\_\_ Hospital Phone Number: (\_\_\_\_) \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Policyholder Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

Treating Doctor's Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Mailing address \_\_\_\_\_

CLAIMANT NAME: **X** \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

If you wish to file a **Wellness/Cancer Screening claim for a test performed within the past 12 months**, you need the name and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number. You may:

- **FILE BY PHONE!** Call 1.800.325.4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week, or
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "Wellness Test." **FAX** this to us at **1.800.880.9325** or **MAIL** to PO Box 100195, Columbia SC 29202.

**If your Wellness/Cancer Screening test was more than one year ago**, you must fax or mail us a copy of the bill or statement from your doctor 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.

**Please note: If your specified disease for cancer policy includes a second part to the screening benefit, bills for tests covered and a copy of the diagnostic report** (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

This claim is for:  Self  Spouse  Dependent: if over 18, name of school \_\_\_\_\_

Name of Claimant \_\_\_\_\_ Name of Policyholder (if not claimant) \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Policy Number: \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street (Apt. #) City State Zip

*(must include street address for overnight delivery)*

**Has your address changed since we last heard from you?**  YES  NO

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Fax Number: (\_\_\_\_) \_\_\_\_\_ Policyholder Email Address: \_\_\_\_\_

**If you are claiming disability, please list the dates you were unable to work: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Please print INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL**

*Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).*

|                                       |
|---------------------------------------|
| <b>Full name of treating doctor</b>   |
| Mailing Address _____                 |
| City _____ State _____ Zip Code _____ |
| (____) _____ (____) _____             |
| Phone number _____ Fax number _____   |
| Email _____                           |

|                                       |
|---------------------------------------|
| <b>Full name of primary doctor</b>    |
| Mailing Address _____                 |
| City _____ State _____ Zip Code _____ |
| (____) _____ (____) _____             |
| Phone number _____ Fax number _____   |
| Email _____                           |

|   |
|---|
| <b>Full name of referring doctor/hospital</b> |
| Mailing Address _____                         |
| City _____ State _____ Zip Code _____         |
| (____) _____ (____) _____                     |
| Phone number _____ Fax number _____           |
| Email _____                                   |

|                                       |
|---------------------------------------|
| <b>Other</b>                          |
| Mailing Address _____                 |
| City _____ State _____ Zip Code _____ |
| (____) _____ (____) _____             |
| Phone number _____ Fax number _____   |
| Email _____                           |

**CERTIFICATION**

**Policyholder/Employee'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. Any person 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.

**PLEASE ALSO SIGN AND DATE THE ENCLOSED AUTHORIZATION.**

**X** \_\_\_\_/\_\_\_\_/\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_  
 Date (mm/dd/yyyy) PATIENT SIGNATURE POLICYHOLDER/EMPLOYEE SIGNATURE

CLAIMANT NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**B. DISABILITY BENEFITS. To be completed and signed by the DOCTOR treating you for this disability:**

Diagnosis/ primary disabling condition/ ICD9 Code(s): \_\_\_\_\_

Secondary conditions contributing to this disability: \_\_\_\_\_

Would the patient be disabled without regards to these secondary conditions?  yes  no

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment: \_\_\_\_\_

Is this condition the result of an accidental injury?  yes  no If yes, please provide us with the date and description. \_\_\_\_\_

Dates of Inpatient Hospital Confinement: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital: \_\_\_\_\_  
Name Address

List any surgeries performed and submit a copy of the operative report. \_\_\_\_\_

Is this patient permanently disabled?  yes  no If yes, what are the permanent restrictions/limitations? \_\_\_\_\_

How soon do you expect significant improvement in the patient's medical condition? \_\_\_\_\_ # weeks/months (circle one)

Dates unable to work: Full Duty: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates unable to work: Partial Duty: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

List Restrictions/Limitations preventing work \_\_\_\_\_

Is this patient considered to be house confined (unable to perform normal daily activities) or unable to perform 2 or more activities of daily living? Yes / No (circle one) If yes, which ADLs cannot be performed? \_\_\_\_\_

For what period? From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_  
(This information will be used in accordance with state regulations and policy provisions.)

Anticipated return to work/release date: \_\_\_\_\_ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

If due to complications of pregnancy prior to delivery, what is EDC? \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of office visits (mm/dd/yyyy): \_\_\_\_\_

Recommended frequency of treatment: \_\_\_\_\_

Signature of doctor: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient #: \_\_\_\_\_

Specialty: \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

**Full name of referring doctor**

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone number Fax number

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

CLAIMANT NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**To be completed and signed by your EMPLOYER:**

Name of Employer: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Employee working at any other place of employment? Employee's Job Title: \_\_\_\_\_

yes  no If yes, where \_\_\_\_\_

Dates this employee has been unable to work:

From: \_\_\_/\_\_\_/\_\_\_ am/pm To: \_\_\_/\_\_\_/\_\_\_ am/pm

From: \_\_\_/\_\_\_/\_\_\_ am/pm To: \_\_\_/\_\_\_/\_\_\_ am/pm

Date employee returned to main or principal duties:

\_\_\_/\_\_\_/\_\_\_  Part time \_\_\_\_\_ Number of hours/week  
 Full time

Date employee returned to light duty: \_\_\_/\_\_\_/\_\_\_

Monthly salary \$ \_\_\_\_\_ Hourly salary \$ \_\_\_\_\_

Did the accident occur while working for wage/profit?

yes  no If yes, list date of injury: \_\_\_/\_\_\_/\_\_\_

Has Workers' Compensation been approved?  yes  no

Name and address of Workers' Compensation carrier:

\_\_\_\_\_

Is modified or light duty available?  yes  no If yes, date available. \_\_\_\_\_

Signed: **X** \_\_\_\_\_ Title: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

**(To be signed by your employer)**

**C. ACCIDENTAL INJURY-** please **complete** and **attach itemized copies** of any related **bills** including **doctor, ambulance, emergency room, and hospital**. Bills should include **diagnosis** information (from your medical provider).

Date of accident (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Time of accident: \_\_\_\_\_ am / pm (circle one)

Tell us how your accident happened:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you at work, working for wage or profit, at the time of your accident?  yes  no

Have you ever had a similar injury? \_\_\_\_\_ If so, please tell us when (mm/dd/yyyy): \_\_\_\_\_

**If you are claiming disability, please have your employer and doctor complete SECTION B.**

CLAIMANT NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**D. HOSPITAL CONFINEMENT OR OUTPATIENT SURGERY BENEFITS.** Please send an itemized copy of your hospital bill which includes the *diagnosis, admission and discharge dates*. Have your doctor complete this section if your bills do not include diagnosis information. Please send a copy of the anesthesiologist bill if outpatient surgery was performed.

Diagnosis/ICD-9 Code: \_\_\_\_\_

Dates of Inpatient Hospital Confinement: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of Confinement including Coronary Care Unit: From \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Hospital Address: \_\_\_\_\_

Date of Surgery (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Inpatient / Outpatient (circle one) Procedure/procedure code: \_\_\_\_\_

Date of office visit following confinement or outpatient surgery (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of doctor: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

***If you are claiming disability, please have your employer and doctor complete SECTION B.***

