Colonial Voluntary Benefits™

Claim Form and Instructions

FAX this direction	FAX this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia, SC 29202	From: Number of pages:

Optional Service Release Agreement

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize The Paul Revere Life Insurance Company to facilitate processing this claim by releasing its details to the following individual(s) inquiring on my behalf. **Note: Leave blank if you do not want anyone accessing your claim information.**

_____ Sales representative _____ Employer _____ Spouse, family member or significant other Name: _____

_____ I want Paul Revere to update me on the status of my claim through prerecorded messaging at my contact number indicated on this form. I understand that messages will be left with anyone who answers the phone or on my answering machine. Note: To avoid blocked calls, you should program the number 1-800-325-4368 into your 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. I also understand that if I want my claim to be sent by overnight delivery, a **$22.00 fee** will be deducted from my claim payment. This fee is subject to rate increases by carrier and does not include weekend delivery. **I understand that Paul Revere is unable to send overnight mail to a P.O. Box.**

I also understand that I must notify Paul Revere to discontinue any of these services.

Additional Information

Wellness/health screenings

If you wish to file a wellness/cancer screening claim for a test performed within the past 36 months, you'll need to submit the type and date of the test performed, as well as your physician's name and phone number. We also need to know if this is for you or another covered individual. If this is for another covered individual, we need his or her name and Social Security number. If you file by telephone or Internet, please retain a copy of the medical information and/or, your receipt if needed for further verification.

You may file by:

- **Phone:** 1-800-325-4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week; or
- **Fax/mail:** 1-800-880-9325 / P.O. Box 100195, Columbia SC 29202 Write your name, address, Social Security number and/or policy/certificate number on your bill and indicate "Wellness Test."

If your wellness/cancer screening test was more than 36 months ago, you must fax or mail us a copy of the bill or statement from your physician 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.

Checklist

- ☐ Social Security number of claimant. Social Security number is indicated by SSN.
- ☐ If your name has changed, attach a copy of your driver's license or other legal documentation.
- ☐ Sign and date "Authorization" page of form
- ☐ Signature and date for each section (physician and/or employer must sign their sections)
- ☐ Dates should be written in month/day/year format (e.g. 12/14/1980).

Use this form when filing under more than one policy.

Complete each section entirely before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim. Please make sure that all written responses are legible.

- Benefits are payable to you unless we receive written authorization to pay benefits elsewhere. This is called an assignment.
- 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.

Complete the sections that apply to your coverage.

- ☐ **If filing for Accident:** Attach itemized copies of any related bills
- ☐ **If filing for Disability:** Section 3 must be completed by your employer. Section 5 must be fully completed by your physician, including diagnosis, treatment and unable to work dates. Include a copy of the hospital bill(s) showing admission and discharge dates, daily room charge(s) and medical expenses incurred. Include copy of the anesthesia bill if outpatient surgery was performed.
- ☐ **If filing for Hospital or Rehabilitation confinement:** Attach a copy of the itemized bill showing the admission and discharge dates and the daily room charges. If not available, have your physician complete and sign section 4A.
- ☐ **If filing for Specified Disease for Cancer:** Attach a copy of the pathology report along with all itemized bills related to the condition.
- ☐ **If filing for Specified Disease for Critical Illness:** Attach all medical information related to the illness.
- ☐ **If filing for Surgery or Diagnostic procedure:** Submit a copy of the itemized surgeon's bill showing the diagnostic/procedure codes and a copy of the operative report. If not available have the physician complete and sign section 4B.

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming 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.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California: 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: 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: 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.

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.

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 and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and civil 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.

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 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.

Please check the type of claim you are filing below:

☐ Accident ☐ Cancer ☐ Critical Illness ☐ Disability ☐ Hospital confinement /outpatient surgery ☐ Routine pregnancy

Section 1 – Claimant statement (completed by policy owner)

Claimant name:			Relationship to policy owner: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic partner
☐ Male ☐ Female	Claimant DOB: _____ / _____ / _____	Claimant SSN:	
Policy owner's name:			DOB: _____/_____/_____ SSN:
Mailing address: Apt. #	City:	State:	ZIP:
Home telephone:	Work telephone:	Policy owner's email:	
Primary physician:	Telephone:	Fax:	
Address:	City:	State:	ZIP:
Referring physician or hospital:	Telephone:	Fax:	
Address:	City:	State:	ZIP:

Section 2 – Accidental injury (completed by policy owner)

Please complete and attach itemized copies of any related bills, including physician, ambulance, emergency room, hospital, and/or rehabilitation unit. Bills should include diagnosis information from your medical provider.

Date the accident occurred (not when it was treated): _____ / _____ / _____ Accident occurred: ☐ On-job ☐ Off-job

Have you been treated for the same or similar condition prior to this occurrence? ☐ Yes ☐ No If yes, when: _____ / _____ / _____

Hospital admission: ☐ Yes ☐ No

Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Description of how the accident occurred **(if auto accident, attach a copy of the accident report):**

Certification

Policy owner's name: _____ SSN: _____

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 two 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: For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:
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 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.

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 the Physician Statement portion of the claim form.

Print claimant's name	Claimant's signature	Date (MM/DD/YYYY)
Print policy owner's name	Policy owner's signature	Date (MM/DD/YYYY)

Claimant name:	**Claimant SSN:**

Section 3 – Employer statement (completed by employer)

Employee name:		SSN:
Employee title:		Hire date: _____ / _____ / _____
Average number of scheduled hours per week:	Date last worked: _____ / _____ / _____	Date employment terminated: _____ / _____ / _____
Employee unable to work (Full-time): From: _____ / _____ / _____ To: _____ / _____ / _____		Sick leave was exhausted on: _____ / _____ / _____
Approved for FMLA (if eligible): From: _____/ _____/ _____ To: _____/ _____/ _____		Was employee at work when accident or sickness occurred? ☐ **Yes** ☐ **No**
Workers' compensation claim filed? ☐ **Yes** ☐ **No**	Workers' compensation carrier Name:	Telephone:
Hourly employee rate:	Hours worked per week:	Annual salary:
Do you permit light duty for employee? ☐ **Yes** ☐ **No**		Do you permit partial duty for employee? ☐ **Yes** ☐ **No**
Expected return to work: _____ / _____ / _____	Actual return to work: Full-time: _____ / _____ / _____	Actual return to work: Part-time: _____ / _____ / _____ Hours per week:_____
Employee's duties include:	☐ **Sitting** _____ per hr. ☐ **Walking** _____ per hr. ☐ **Climbing stairs/ladders** _____ per hr. ☐ **Standing** _____ per hr. ☐ **Driving** _____ hrs. per day	
	Lifting: ☐ Less than 15 lbs. ☐ 15 to 44 lbs ☐ More than 45 lbs. **Stooping/bending:** ☐ none ☐ seldom ☐ frequent	
Reaching/pulling/pushing: ☐ none ☐ seldom ☐ frequent **Crawling/kneeling:** ☐ none ☐ seldom ☐ frequent **Repetitive motion:** ☐ none ☐ seldom ☐ frequent		
Contact for updates on return to work status:		Telephone:
Email:		Fax:

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes employer's portions of the claim form.

_____ Signature of authorized person	_____ Date (MM/DD/YYYY)
Title of authorized person:	Employer/company name:
Telephone: Fax:	Email:

Section 4A – Hospital confinement/rehabilitation confinement (completed by physician)

Please submit the following with your claim: a copy of the itemized bill showing the admission and discharge dates and the daily room charges. If you are unable to provide billing statements, please have your doctor complete and sign the claim form.

Diagnosis/ICD codes:	**Diagnostic procedure date** _____ / _____ / _____	Diagnostic procedure code/description:

Hospital:			Telephone:
Address:	City:	State:	ZIP:
Admitting physician:			Telephone:
Address:	City:	State:	ZIP:
Treating physician:			Telephone:
Address:	City:	State:	ZIP:

Hospital confinement:
Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Intensive care unit confinement:
Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Rehabilitation unit confinement:
Admission date: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Date released: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM

Claimant name:	**Claimant SSN:**

Section 4A – Hospital confinement/rehabilitation confinement – continued (completed by physician)

PREGNANCY	If complications due to pregnancy, complete section 5	Date first treated for pregnancy: _____ / _____ / _____	Date of delivery: _____ / _____ / _____	Type of delivery: ☐ Vaginal ☐ C-section Surgical procedure code:

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes attending physician portions of the claim form.

_____ Signature of physician completing this form	_____ Date (MM/DD/YYYY)

Physician name:		Patient account number:	
Address:	City:	State:	ZIP:
Tax ID or SSN:	Telephone:	Fax:	
Will you accept the standard HIPAA release? ☐ **Yes** ☐ **No**	Do you accept medical record requests by fax? ☐ **Yes** ☐ **No**		
Do you require a special authorization for release of information? ☐ **Yes** ☐ **No**	Authorization on file to release information to Paul Revere: ☐ **Yes** ☐ **No**		

Section 4B – Surgery/Diagnostic Procedure (completed by physician)

Please submit the following with your claim: a copy of the itemized surgeon's bill showing the diagnostic/procedure codes and a copy of the operative report. If you are unable to provide billing statements, please have your doctor complete and sign the claim form.

Surgery: ☐ Inpatient ☐ Outpatient **Location:** ☐ Hospital ☐ Ambulatory Surgery Center Name of Facility where procedure performed _____ Admission: _____ / _____ / _____ Time:_____ ☐ AM ☐ PM Released:_____ / _____ / _____ Time:_____ ☐ AM ☐ PM	**Surgery procedure description/code(s):**

Anesthesia administered? ☐ Yes ☐ No	Anesthesia administered by a licensed anesthesiologist? ☐ Yes ☐ No	Is condition due to an accidental injury? ☐ Yes ☐ No

Physician office visit(s) following surgery:

1. _____ / _____ / _____ 2._____ / _____ / _____ 3._____ / _____ / _____ 4._____ / _____ / _____

Diagnostic procedures: Date: _____ / _____ / _____ Code:_____ Date: _____ / _____ / _____ Code:_____	**Diagnosis/ICD codes:**

Fraud warning: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes attending physician portions of the claim form.

_____ Signature of physician completing this form	_____ Date (MM/DD/YYYY)

Physician name:		Patient account number:	
Address:	City:	State:	ZIP:
Tax ID or SSN:	Telephone:	Fax:	
Will you accept the standard HIPAA release? ☐ **Yes** ☐ **No**	Do you accept medical record requests by fax? ☐ **Yes** ☐ **No**		
Do you require a special authorization for release of information? ☐ **Yes** ☐ **No**	Authorization on file to release information to Paul Revere: ☐ **Yes** ☐ **No**		

Claimant name:	**Claimant SSN:**

Section 5 – Physician Statement (completed by physician)

Patient name:	DOB: _____ / _____ / _____
Is condition due to an accidental injury? ☐ Yes ☐ No	If yes, date and description of accidental injury:
What primary diagnosis prevents the patient from working? (If pregnancy, list complications. If routine pregnancy, complete information below.)	Date first treated for this condition: _____/_____/_____
Are there any secondary diagnoses preventing the patient from working? ☐ **Yes** ☐ **No**	Secondary diagnoses:
When did symptoms first appear? _____ / _____ / _____	Date of new patient consultation: _____ / _____ / _____ / Symptoms:
Current treatment plan:	
List all dates patient received: medical advice, diagnosis or treatment for this condition (or a related condition) for the 18 months prior to this disability to the present.	(list dates: MM/DD/YYYY)
List any test performed (submit copy of test results) Date: _____/_____/_____ CPT code: _____ Date: _____/_____/_____ CPT code: _____	List any surgeries performed (submit copy of operative report) Date: _____/_____/_____ CPT code: _____ Date: _____/_____/_____ CPT code: _____
Date of patient's last visit: _____ / _____ / _____ / Date of next scheduled visit: _____ / _____ / _____	How soon do you expect significant improvement in the patient's medical condition? ☐ 1 - 2 months ☐ 3 - 4 months ☐ 5 - 6 months ☐ more than 6 months
Does patient have permanent restrictions and/or limitations? ☐ **Yes** ☐ **No** If yes, which ones are permanent:	Limitations (patient CANNOT DO): / Restrictions (patient SHOULD NOT DO):
Dates unable to work (full-time): From: _____ / _____ / _____ To: _____ / _____ / _____	**Expected return to work:** _____ / _____ / _____
Dates able to work (part-time): From: _____ / _____ / _____ To: _____ / _____ / _____ Number of hours worked:_____	**Actual return to work:** _____ / _____ / _____
Did this condition require house confinement: ☐ Yes ☐ No If yes, dates: _____/_____/_____ To: _____/_____/_____ House confinement means the patient is kept at home (in house or yard) by the condition. However, the patient may follow your orders, even if it means leaving home.	
Check activities of daily living that the patient is unable to perform: ☐ Dressing ☐ Eating ☐ Meal preparation ☐ Bathing ☐ Transferring ☐ Toileting ☐ Continence	
Dates unable to perform activities of daily living: From: _____ / _____ / _____ To: _____ / _____ / _____	
Date(s) of hospitalization (last 6 months):	Date(s) of office visit (last 6 months):

How often do you see the patient?	Have you referred patient to a specialist? ☐ **Yes** ☐ **No**
Hospital:	Specialist:
Address: / State: / ZIP:	Address: / State: / ZIP:
Telephone: / Fax:	Telephone: / Fax:
PREGNANCY Estimated date of delivery: _____ / _____ / _____	Type of delivery: ☐ Vaginal ☐ C-section
Date first treated: _____ / _____ / _____ / Date of delivery: _____ / _____ / _____	Procedure code:

Fraud warning: **Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.**

_____ Physician signature	_____ Date (MM/DD/YYYY)
Physician/group name:	Patient account number:
Physician's specialty: / Telephone: / FAX:	
Address: / State: / ZIP:	
Tax ID or SSN:	Do you accept medical record requests by fax? ☐ Yes ☐ No
Do you require a special authorization for release of information? ☐ **Yes** ☐ **No**	Patient Portal: ☐ **Yes** ☐ **No** / Will you accept the standard HIPAA release? ☐ **Yes** ☐ **No**
Was patient referred to you by another physician? ☐ **Yes** ☐ **No**	Authorization on file to release information to Paul Revere: ☐ **Yes** ☐ **No**
Referring physician:	Telephone: / Fax:
Address:	City: / State: / ZIP:

Authorization for The Paul Revere Life Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Paul Revere Life Insurance Company and its duly authorized representatives (Paul Revere).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Paul Revere to evaluate my application or claim forms.

Any information Paul Revere obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. Some information, once 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. Paul Revere will not re-disclose the information unless permitted or required by those laws or as authorized by me.

I also authorize Paul Revere to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Paul Revere; or, the Social Security Administration. Paul Revere will not condition the payment of insurance benefits on whether I authorize Paul Revere to re-disclose my information. For the purposes of these disclosures by Paul Revere, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), 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. This authorization may be revoked by me or my authorized representative at any time except to the extent Paul Revere 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 I do not sign this authorization or if I alter or revoke it, except as specified above, Paul Revere may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

_____ _____

Signature | Date signed (MM/DD/YYYY)

_____ XXX-XX-_____ _____

Printed name of individual subject to this disclosure | Last four digits of SSN | Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_____ _____ _____

Printed name of legal representative | Signature of legal representative | Date signed (MM/DD/YYYY)

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