# Critical Illness Claim Form

**File claims using the Online Service Center (OSC) for faster payments, claim status updates, direct deposit and more.**
**Sign up or log in now!**

**Instructions for the Insured or Patient**

- Complete the Statement of Insured (Sections A through F) as applicable to your claim.
- Completing Section G is not required; however, completing this section will reduce delays in processing should we need to request additional information regarding your claim.
- The following benefits require supporting documentation (refer to your Policy/Certificate for benefits covered under your plan.) The indicated documentation must accompany the completed Statement of Insured when filing a claim:
    - Critical Illness Benefit, provide Medical Records[1] and the completed Attending Physician's Statement. The Critical Illness Benefit may include a first-time diagnosis, additional diagnosis, and/or a recurrent diagnosis, depending on your specific plan coverage.
    - Ambulance, Genetic Testing, Health Screening, Hospice Care, Hospital Confinement, Mammography, Mental Health Benefits, Second Opinion or Vaccine Benefits, provide an Itemized Medical Bill[2]
    - Hospitalization Due to Infectious Disease Benefit, provide an Itemized Medical Bill[2] and sections H1 through H2 and H29 of the Attending Physician's Statement
    - Family Caregiver Benefit, provide documentation from the employer that the Insured utilized paid time off must be submitted and sections H1, H2 and H29 of the Attending Physician's Statement
    - Accidental Death, provide a copy of the Death Certificate[3]
    - Repatriation Benefit, provide a copy of the Death Certificate[3] and an Itemized Invoice[4] or Itemized Receipt[5]
    - Accidental Dismemberment, provide Medical Records[1]
    - Will Preparation Benefit, provide a copy of the Death Certificate[3] and an Itemized Invoice[4] or Itemized Receipt[5]
    - Non-Local Transportation Benefit, provide an Itemized Invoice[4] or Itemized Receipt[5]
    - Family Member Lodging Benefit, provide an Itemized Invoice[4] or Itemized Receipt[5] and Itemized Medical Bill[2]
- Your signature is required for benefit consideration

[1]Medical Records should support diagnosis of the condition and include laboratory analysis, pathology report, imaging studies, other tests, and office notes
[2]The itemized medical bill must include the diagnosis for which treatment was provided and the procedures that were performed. A copy of the standardized claim forms, commonly called a UB or CMS form, may be submitted in lieu of the itemized bill.
[3]Original copies of death certificate will be returned.
[4, 5] The itemized invoice, or itemized receipt, should include the service or item purchased, each date of service or date of purchase, charge amount, and vendor or company name, address location, and telephone number. The itemized invoice or itemized receipt should also include the origin and destination location when filing a claim for Repatriation and Non-Local Transportation.

# Critical Illness Claim Form

## STATEMENT OF INSURED

### Section A - About the Insured

| First Name | MI | Last Name | Suffix |
|---|---|---|---|
| | | | |

| Date of Birth | Social Security Number **or** Policy Number(s) |
|---|---|
| | |

| Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Home Phone Number | Cell Phone Number | Email Address |
|---|---|---|
| | | |

### Section B – About the Patient

| First Name | MI | Last Name | Suffix | Date of Birth |
|---|---|---|---|---|
| | | | | |

### Section C – About the Critical Illness or Condition

Refer to your Policy/Certificate for benefits covered under your plan

Date of Diagnosis

Has the Patient previously filed a claim for a Critical Illness Benefit? ☐ Yes ☐ No

If yes, is this claim being filed for the same Critical Illness as the previously filed claim? ☐ Yes ☐ No

### Section D – Benefits Claimed - Select the condition(s) for which this claim is being filed

| | | |
|---|---|---|
| ☐ Ambulance | ☐ Health Screening | ☐ Mental Health |
| ☐ Accidental Death & Dismemberment | ☐ Hospice Care | ☐ Repatriation |
| ☐ Critical Illness Benefit | ☐ Hospital Confinement | ☐ Second Opinion |
| ☐ Family Caregiver | ☐ Hospitalization due to Infectious Disease | ☐ Vaccine |
| ☐ Genetic Testing | ☐ Mammography | ☐ Will Preparation |

### Section E – Non-Local Transportation

| Begin Date of Travel | Method of Travel | Treating Location | | | |
|---|---|---|---|---|---|
| | | Street | City | State | Zip |
| | | | | | |
| | | | | | |

### Family Member Lodging

| Begin Date of Travel | Family Member's Address | | | Treating Location | | | Relationship to Patient |
|---|---|---|---|---|---|---|---|
| | City | State | Zip | City | State | Zip | |
| | | | | | | | |
| | | | | | | | |

### Acknowledgement - Your signature is required for benefit consideration

I hereby certify the answers I have provided in the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice included in this claim form.

Signature of Insured/Beneficiary

Date Signed

# Critical Illness Claim Form

## Section F – Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

**If you live in a jurisdiction not mentioned below, the following applies to you:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

**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.

**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.

**Arkansas, District of Columbia, Louisiana, Rhode Island and 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.

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, Idaho and 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.

**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.

**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.

**Maine, Tennessee, Virginia and 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 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.

**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.

**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.

For your protection **Texas** law requires the following to appear on this form: 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.

# Critical Illness Claim Form

## Section G - Authorization to Request Information Including Protected Health Information

The purpose of this form is to allow American Public Life Insurance Company (APL), or business partners acting on behalf of APL in the administration of APL products and services to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, APL may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my Customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing APL who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities or their business associates; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. APL will only disclose any data collected pursuant to this authorization as necessary for legitimate business purposes, and only to the extent allowed by law.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which I may have been treated.

I understand APL may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. I understand I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or an inability to pay benefits under my policy if my failure to sign results in APL not having enough information to process my benefits. I understand I may revoke this authorization at any time by writing to APL, P.O. Box 248950, Oklahoma City, OK 73124-8950 or by calling 800-256-8606. I understand that my right to revoke this authorization is limited to the extent that: APL has acted in reliance on the authorization; or the law provides APL with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations. In addition to the types of information described above, I also authorize APL to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to APL.

For health insurance coverage, this authorization will expire 24 months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire 24 months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

| APL Policy Number | Printed Name of Patient | Patient's Date of Birth |
|---|---|---|
| | | |

| Signature (*Patient*) or Personal Representative (*if applicable*) | Date Signed |
|---|---|
| | |

Relationship of Personal Representative to Patient *(if applicable)*
*If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.*

# Critical Illness Claim Form

## ATTENDING PHYSICIAN'S STATEMENT

### Instructions for the Physician

- Complete the Attending Physician's Statement (Sections H1 through H6) as applicable to your Patient.
- Send the signed Attending Physician's Statement and supporting documentation to the address or fax number listed above.

### H1 - Patient Information

| First Name | MI | Last Name | Suffix |
|---|---|---|---|
| | | | |

| Date of Birth | Social Security Number **or** Policy Number(s) |
|---|---|
| | |

### H2 - About the Diagnosis and Treatment

| Primary Diagnosis Code | Primary Diagnosis Description | Date of Diagnosis | Date Patient first consulted you for this Condition |
|---|---|---|---|
| | | | |

Has the Patient ever had the same or a similar condition? ☐ Yes ☐ No If yes, date previously diagnosed

Describe the previous condition

Is the condition due to an accident? ☐ Yes ☐ No If yes, date of accident

Has a Physician certified, due to this condition, the Patient requires substantial assistance from another adult to perform the following

Bathing: washing oneself by sponge bath or in the tub or shower, including the task of getting into or out of the tub or shower

☐ Yes ☐ No

Dressing: putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs

☐ Yes ☐ No

Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously

☐ Yes ☐ No

Transferring: moving into and out of bed or a wheelchair

☐ Yes ☐ No

Toileting: getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene

☐ Yes ☐ No

Continence: the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag)

☐ Yes ☐ No

If yes, date of certification

Is the Patient still under your care? ☐ Yes ☐ No If yes, date the Patient was last seen

If the Patient was referred to you, provide the contact details of the referring Physician

| First Name | | Last Name | |
|---|---|---|---|
| Contact Number | | Address | |
| City | | State | Zip Code |

### H3 – Advanced Parkinson's Disease

Date of Diagnosis

Does the Patient exhibit any of the following due to Advanced Parkinson's Disease? (Check all that apply)

☐ Muscle Rigidity ☐ Tremor ☐ Bradykinesia

### H4 – Brain Tumor

Date of Diagnosis

Has the presence of a benign brain tumor been established by examination of tissue through a biopsy or surgical excision or by a specific neuroradiological examination? ☐ Yes ☐ No If yes, date of biopsy/exam

Is the brain tumor limited to the brain, meninges, cranial nerves, or pituitary gland? ☐ Yes ☐ No

Is surgery required? ☐ Yes ☐ No Is radiation treatment required? ☐ Yes ☐ No

Are there irreversible objective neurological deficits? ☐ Yes ☐ No

# Critical Illness Claim Form

## H5 – Bone Marrow Transplant

Date of determination

Has a hematologist or oncologist determined that the Patient requires a bone marrow transplant because the Patient's is unable to appropriately produce blood cells? ☐ Yes ☐ No

## H6 – Severe Burns

Date of Injury

What percentage of the total body surface area has been burned?

Indicate the degree and thickness of the burn that the Patient has suffered below

Degree ☐ 1st degree ☐ 2nd degree ☐ 3rd degree ☐ 4th degree

Thickness ☐ Partial thickness ☐ Full thickness

## H7 – Cancer

Date of Diagnosis

Has a biopsy been performed? ☐ Yes ☐ No Diagnosis Code Stage

Check the most appropriate classification for the Cancer (Check one)

☐ In situ ☐ Invasive ☐ Metastatic

Does treatment for this Condition require any of the following? (Check all that apply)

☐ Chemotherapy ☐ Immunotherapy ☐ Radiation Therapy ☐ Surgical Removal Date of surgery

## H8 – Cardiac Arrythmia

Date of Recommendation

Has a board-certified cardiologist recommended that, due to an irregular heartbeat caused by electrical conduction abnormalities, an automatic implantable cardioverter defibrillator or pacemaker be surgically placed in the Patient's chest to deliver electrical pulses to the heart to keep a normal pace and/or rhythm? ☐ Yes ☐ No

## H9 – Coma

Date continuous state of unconsciousness began

For how many consecutive days has the Patient experienced a state of unconsciousness with no reaction to external stimuli or response to internal needs?

Was/Is the state of unconsciousness medically induced? ☐ Yes ☐ No

Was/Is the state of unconsciousness a direct result from alcohol or drug use? ☐ Yes ☐ No

## H10 – Complete Loss of Hearing

Date of Examination

Has the Patient experienced a total and irreversible loss of hearing in both ears? ☐ Yes ☐ No

For how long is the loss expected to persist?

Can the loss of hearing be corrected by any procedure, aid, or device? ☐ Yes ☐ No

| Results of | Right Ear | Left Ear |
|---|---|---|
| Auditory threshold (in decibels) | | |
| Speech threshold (in hertz) | | |

## H11 – Complete Loss of Sight

Date of Test

Has the Patient experienced a total and irreversible loss of vision in both eyes? ☐ Yes ☐ No

For how long is the loss expected to persist?

Can the loss of vision be corrected by any procedure, aid, or device? ☐ Yes ☐ No

| Results of | Right Eye | Left Eye |
|---|---|---|
| Visual acuity (in feet) | | |
| Field of vision (in degrees) | | |

## H12 – Complete Loss of Speech

Date of Examination

Has the Patient experienced a total and irreversible loss of the ability to speak or communicate verbally without assistance of a medical device? ☐ Yes ☐ No

For how long is the loss expected to persist?

Can the loss of speech be corrected by any procedure, aid, or device? ☐ Yes ☐ No

# Critical Illness Claim Form

## H13 – Coronary Artery Disease

Date of Examination

Has the Patient been diagnosed with coronary artery disease? ☐ Yes ☐ No

Has a physician board-certified as a cardiologist recommended that the Patient undergo one of the following procedures?

(Check all that apply) ☐ Angioplasty ☐ Atherectomy ☐ Open heart surgery

If the Patient is too ill to undergo one of the above listed procedures, would one of these procedures otherwise be recommended due to the severity of the Coronary Artery Disease? ☐ Yes ☐ No

## H14 – Cystic Fibrosis

Date of Diagnosis

Date chloride sweat test was performed

Results millimoles per liter

## H15 – End Stage Renal Failure

Does the Patient have End Stage Renal Failure presenting as irreversible failure to function of both kidneys and confirmed by a physician board certified as a nephrologist? ☐ Yes ☐ No

Does the Patient's kidney failure necessitate regular hemodialysis or peritoneal dialysis (at least weekly) or kidney transplantation?

☐ Yes ☐ No If yes, date determination made for renal dialysis/kidney transplant

Is the Patient too ill to undergo surgery? ☐ Yes ☐ No

If yes, would surgery or placement on the United Network of Organ Sharing (UNOS) list be otherwise recommended due to End Stage Renal Failure? ☐ Yes ☐ No

If no, has the Patient been placed on UNOS list? ☐ Yes ☐ No If yes, date placed on UNOS list

## H16 – Heart Attack

Has the Patient suffered a Heart Attack resulting in the death of a portion of the heart muscle due to blockage of one or more coronary arteries? ☐ Yes ☐ No

Date EKG performed showing findings consistent with new MI or ☐ not performed/not conclusive

Date laboratory test(s) performed showing cardiac enzymes above standard laboratory levels of normal cases of creatine, phosphokinase, or CPK or ☐ not performed/not conclusive

Additional test(s) performed to support Diagnosis of a myocardial infarction

| Name of Test | Date Performed | Results |
|---|---|---|
| | | |
| | | |
| | | |

## H17 – Heart Valve Surgery

Date of Recommendation

Has a physician board-certified as a cardiologist recommends a cardiac surgery procedure to replace the Patient's mitral or aortic, or both, valves by a different valve due to a disease of the heart? ☐ Yes ☐ No

## H18 – Hepatitis or HIV

Date of Diagnosis

Check the condition for which the Patient is being treated ☐ Hepatitis ☐ HIV

Is this condition the result of an accidental needle stick or sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid? ☐ Yes ☐ No

Did accidental exposure occur during the normal course of duties of the Patient's occupation? ☐ Yes ☐ No

List the date on which blood test was performed following accidental exposure and the result

| | Date Performed | Results | |
|---|---|---|---|
| Initial blood test | | ☐ Positive | ☐ Negative |
| Subsequent blood test | | ☐ Positive | ☐ Negative |

# Critical Illness Claim Form

## H19 – Huntington's Disease

Date of Diagnosis

Does the Patient exhibit any of the following symptoms due to Huntington's Disease? (Check all that apply)

- ☐ Depression
- ☐ Difficulty swallowing
- ☐ Forgetfulness
- ☐ Impaired judgement
- ☐ Involuntary movement
- ☐ Mood swings
- ☐ Personality changes
- ☐ Slurred speech
- ☐ Unsteady gait

Has the Patient undergone genetic testing to confirm the presence of mutation of the HTT gene? ☐ Yes ☐ No

## H20 – Multiple Sclerosis

Date of Diagnosis

Has a neurological examination been performed? ☐ Yes ☐ No If yes, date of examination

Did examination demonstrate functional impairments? ☐ Yes ☐ No/Not performed

Have neurological deficits been present for at least six (6) months? ☐ Yes ☐ No

Have imaging studies of brain or spine demonstrated lesions consistent with MS? ☐ Yes ☐ No/Not performed

If yes, date study performed

Has analysis of cerebrospinal fluid resulted in findings consistent with MS? ☐ Yes ☐ No/Not performed

## H21 – Major Organ Failure

Has the Patient experienced failure or loss of one or more of the following organs for which a Physician recommends a surgical transplant of a human organ? (Check all that apply)

☐ Heart ☐ Liver ☐ Lung ☐ Pancreas Date on which recommendation was made

Is the Patient too ill to undergo surgery? ☐ Yes ☐ No

If yes, would surgery or placement on the United Network of Organ Sharing (UNOS) list be otherwise recommended due to the organ failure? ☐ Yes ☐ No

If no, has the Patient been placed on the UNOS list? ☐ Yes ☐ No If yes, date placed on UNOS list

What condition(s) caused the major organ failure?

List the Patient was first treated for signs/symptoms of this condition(s)

## H22 – Muscular Dystrophy

Date of Diagnosis

Has an electromyography been performed? ☐ Yes ☐ No If yes, date performed

Has a muscle biopsy been performed? ☐ Yes ☐ No If yes, date performed

If yes, do findings support abnormalities consistent with muscular dystrophy? ☐ Yes ☐ No

Has an electromyography been performed? ☐ Yes ☐ No

## H23 – Permanent Paralysis

Date of Diagnosis

Does the Patient have damage to the brain or spinal cord that resulted in permanent paraplegia or quadriplegia? ☐ Yes ☐ No

For how many consecutive days has/had this condition persisted?

Is this condition expected to be permanent? ☐ Yes ☐ No

## H24 – Ruptured Aneurysm

Date of Diagnosis

Has a radiological study been performed? ☐ Yes ☐ No If yes, date performed

If yes, type of radiological study performed

## H25– Spina Bifida

Date of Diagnosis

Indicate the type of Spina Bifida with which the Patient has been diagnosed. (Check all that apply)

☐ Meningocele ☐ Myelomeningocele ☐ Spina Bifida Occulta

## H26 – Severe Mental Illness

Indicate condition(s) with which the Patient has been diagnosed by a Psychiatrist and the date of diagnosis (Check all that apply)

| Condition | Date of Diagnosis | Condition | Date of Diagnosis |
|---|---|---|---|
| ☐ Obsessive-Compulsive Disorder | | ☐ Severe Bipolar I Disorder | |

# Critical Illness Claim Form

| Condition | Date of Diagnosis | Condition | Date of Diagnosis |
|---|---|---|---|
| ☐ Schizophrenia | | ☐ Severe Major Depressive Disorder | |

Is the diagnosed condition(s) caused by the direct physiological effects of drug use or substance abuse? ☐ Yes ☐ No

Is the diagnosed condition(s) sufficiently severe to cause significant impairment in social, occupational, or educational functions?

☐ Yes ☐ No

At the direction of a Psychiatrist, has the Patient been confined for treatment of this condition(s)? ☐ Yes ☐ No

If yes, was the confinement caused by or contributed to by the Patient's failure to use medication in the manner prescribed by a Physician or other medical professional? ☐ Yes ☐ No

## H27 – Stroke

Date of Diagnosis

Has the Patient experienced an acute cerebral vascular incident (stroke) that resulted in permanent, neurological impairment and resulting in paralysis or another measurable objective neurological defect? ☐ Yes ☐ No

Has a Physician determined that the neurological impairment resulted from the cerebral vascular event currently being diagnosed and was not previously present? ☐ Yes ☐ No

Was the cerebral vascular incident confirmed by (check one) ☐ a clinical diagnosis or ☐ neuroimaging studies?

If this episode was confirmed by neuroimaging studies

Type of study performed | Date performed

Is the cerebral vascular incident a result of damage to brain tissue caused by one of the following (check all that apply)

☐ Thrombosis ☐ Hemorrhage ☐ Embolism

For how many consecutive days has/had the deficit persisted as a result of the stroke?

Was this event caused by any of the following? (Check all that apply)

- ☐ Transient Ischemic Attacks (TIA)
- ☐ Brain injuries related to trauma or infection
- ☐ Vascular disease affecting the eye or optic nerve
- ☐ Brain injuries associated with hypoxia, anoxia or hypertension
- ☐ Ischemic disorders of the vestibular system

## H28 – Transient Ischemic Attack (TIA)

Date of Diagnosis

Has the Patient experienced a transient episode of neurologic dysfunction caused by focal brain, spinal cord or retinal ischemia, without acute infarction? ☐ Yes ☐ No

Was this episode confirmed by (check one) ☐ a documented neurological deficit or ☐ neuroimaging studies?

If this episode was confirmed by neuroimaging studies

Type of study performed | Date performed

Does the evidence of a TIA show any of the following

- ☐ A new ischemic event with no cerebral tissue damage and reversible impairment as confirmed by a clinical diagnosis
- ☐ A clinical diagnosis that includes documentation of recommended treatment for Stroke prevention
- ☐ Impairment that is focal and confined to an area of the brain perfused by a specific artery
- ☐ Is this attack classified as a reversible ischemic neurologic deficit (RIND)

## H29 - Attending Physician Information, Acknowledgement and Signature

| Physician's First Name | Physician's Last Name | Degree | Specialty |
|---|---|---|---|
| | | | |

| Physician's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Physician's Telephone Number | IRS Identification Number |
|---|---|
| | |

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.
I acknowledge that I have read the fraud notices included in this claim form.

| Physician's Signature | Date Signed |
|---|---|
| | |