CRITICAL ILLNESS WELLNESS BENEFIT CLAIM FORM
INSTRUCTIONS

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail or fax the completed form to the address/number shown below.

Send all claims to:

Continental American Insurance Company
Critical Illness Claims Processing Unit
Post Office Box 427
Columbia, South Carolina 29202
Fax – (866) 849-2970

POLICYHOLDER/CLAIMANT'S INFORMATION

POLICYHOLDER'S NAME	POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX

POLICYHOLDER'S ADDRESS	POLICYHOLDER'S TELEPHONE NO.

CLAIMANT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	CLAIMANT'S DATE OF BIRTH	

HEALTH SCREENING INFORMATION

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:

- ☐ STRESS TEST ON A BICYCLE OR TREADMILL
- ☐ SERUM CHOLESTEROL TEST (HDL AND LDL)
- ☐ CA 15-3 (BLOOD TEST FOR BREAST CANCER)
- ☐ CHEST X-RAY
- ☐ HEMOCULT STOOL ANALYSIS
- ☐ PSA (BLOOD TEST FOR PROSTATE CANCER)
- ☐ FASTING BLOOD GLUCOSE TEST
- ☐ BONE MARROW TESTING
- ☐ CA 125 (BLOOD TEST FOR OVARIAN CANCER)
- ☐ COLONOSCOPY
- ☐ THERMOGRAPHY
- ☐ SERUM PROTEIN ELECTROPHORESIS (MYELOMA)
- ☐ MAMMOGRAPHY (date)_____
- ☐ BLOOD TEST FOR TRIGLYCERIDES
- ☐ BREAST ULTRASOUND
- ☐ CEA (BLOOD TEST FOR COLON CANCER)
- ☐ FLEXIBLE SIGMOIDOSCOPY
- ☐ PAP SMEAR (date)_____
- ☐ OTHER

DATE THE HEALTH SCREENING TEST WAS PERFORMED (treatment date **MUST** be provided _____

Physician Information

Name	Phone Number	
Street Address		
City	State	Zip

AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information of me, to give to Continental American Insurance Company or its legal representative, any and all such information. This Information is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug or alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. I UNDERSTAND the information obtained by use of the Authorization will be used by Continental American Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Continental American Insurance Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE that this Authorization shall be valid for the duration of my claim.

Policyholder's Signature: Date: Claimant's Signature: Date: