Fax to: Claims 1.800.880.9325
From:_______________________________
Fax Number:_________________________
Date:_______________________________
Number of pages:____________________

Non-Disability Claim Form and Instructions

Airline Division

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 5.
- ❑ **Complete** the sections that apply to your specific claim.
  Please have your **doctor** complete their section(s), 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 will need to determine if the condition is **pre-existing.** We may have to write your treating physician(s) 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 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.
- **Please do not mail the original document but keep it for your records.**
- **Have your payment returned by overnight delivery,** by initialing the Service Release below. An $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 Colonial Life & Accident Insurance Company to facilitate processing this claim by releasing its details if he/she is inquiring on my behalf.

_____ (initial) Local sales representative _____ (initial) plan administrator ______ (initial) spouse, family member or significant other.

_____ (initial) I authorize Colonial Life & Accident Insurance Company to communicate information on the status of this 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.

_____ (initial) Yes, please deduct the $18.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from 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 Colonial Life 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 Colonial Life & Accident 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: X** ____________________

Colonial Life is the marketing brand for Colonial Life & Accident Insurance Company. Visit us online at coloniallife.com

Mail to: **Colonial Life & Accident Insurance Company**
PO Box 100195
Columbia SC 29202-3195

Fax to: 1.800.880.9325
If you fax your claim, there is no need to mail the original. Reminder: Please copy the back pages and fax all the pages of the claim together.

To avoid unnecessary delays, please be sure you sign and return the attached Certification on page 3 and Authorization on page 5.

- ❑ **Accidental Injury** - Section A, page 4, requests specific information from you about the circumstances of your injury. Please include an itemized copy of your emergency room, doctor office, and/or hospital bills.

- ❑ **Wellness** - if you wish to file a **Wellness** claim for a procedure performed within the past 12 months, you can **FILE BY PHONE!** You'll need the name and date of the test performed as well as your doctor's telephone number for each visit. We also need to know if this is for you or another covered individual and their name and social security number. 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**

- ❑ **SUBMIT ON THE INTERNET** using the Wellness Claim Form at **coloniallife.com.** You'll need the name and date of the test performed as well as your doctor's telephone number for each visit. We also need to know if this is for you or another covered individual and their name and social security number.

If your Wellness test was performed more than one year ago, please complete Section B, page 4, and 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 include your full name, social security number, current address and policy/certificate number on your bill and indicate "**Wellness Test.**" **FAX** this to us at **1.800.880.9325** ***or*** **MAIL** to P.O. Box 100195, Columbia SC 29202. **Please note: If your 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.** Please complete Section B and enclose all related bills.

- ❑ **Cancer** - Have your doctor complete Section C, page 4. Please complete the sections that apply to your coverage.
  - 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. Also, please include a copy of your itemized bills that provide the surgical procedure code(s) and charges for each lesion removed. This information should provide all doctors complete names, mailing addresses and telephone numbers
  - *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 and send an itemized copy of your hospital.

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 to successfully complete this process.

To avoid unnecessary delays, please check the type of claim you are filing below and be sure you sign and return the attached Certification on page 3 and Authorization on page 5.

- ❑ **Accidental Injury**- Section A, page 4, requests specific information from you about the circumstances of your injury. Please include an itemized copy of your emergency room, doctor office, and/or hospital bills.
- ❑ **Wellness - FILE BY PHONE!** Call 1.800.325.4368 **or** Submit on the Internet, 24 hours per day, 7 days a week if you wish to file a **Wellness** claim for a procedure performed **within the past 12 months**. You'll need the name and date of the test performed as well as your doctor's telephone number for each visit. See the top of page 2 for additional instructions or Section B, page 4.
- ❑ **Cancer** - Have your doctor complete Section C, page 4, and send an itemized copy of your hospital bill and pathology report. See the bottom of page 2 for additional instructions.

This claim is for: ❑ Self ❑ Spouse ❑ Dependent: if over 18, name of school:____________________

Name of Claimant:____________________ Name of Policyowner: (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 code

(must include a street address for the overnight delivery option.)

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

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

Fax Number: (______) ____________________Policyowner Email Address:____________________

***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).

1. ____________________
Full name of treating doctor
____
Mailing Address
____
City State Zip code
(____)______________ (____)______________
Phone Number Fax Number

2. ____________________
Full name of referring doctor/hospital
____
Mailing Address
____
City State Zip code
(____)______________ (____)______________
Phone Number Fax Number

3. ____________________
Full name of primary doctor
____
Mailing Address
____
City State Zip code
(____)______________ (____)______________
Phone Number Fax Number

4. ____________________
Other
____
Mailing Address
____
City State Zip code
(____)______________ (____)______________
Phone Number Fax Number

CERTIFICATION

Policyowner/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 ATTACHED AUTHORIZATION ON PAGE 5.

X______/______/_______ **X** ____________________ **X** ____________________

Date (mm/dd/yyyy) PATIENT SIGNATURE POLICYOWNER/EMPLOYEE SIGNATURE

CLAIMANT NAME: X ________________________________ SOCIAL SECURITY NUMBER: ________________

A. ACCIDENTAL INJURY- please complete and attach itemized copies of any related bills including emergency room, doctor, hospital and/or ambulatory surgical center. Bills should include diagnosis information from your medical

Date of accident (mm/dd/yyyy): ____/_____/_____ **Time of accident:** ____________________ am / pm (circle one)
Tell us how your accident happened:

____

____

Date(s) of doctor office visit(s) following treatment for your accident: (mm/dd/yyyy): ________________________________
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): ____________________________

HOSPITAL CONFINEMENT **Dates of Service**

Place of Confinement	**From** (mm/dd/yyyy)	**To** (mm/dd/yyyy)
Intensive Care Unit (Coronary, Sub-acute, etc.)		
Hospital (Private, Semi-Private, Other)		

Diagnosis/ICD-9 Code(s): ____
Hospital: ____ Phone Number: (_____)__________________
Hospital Address: ____

SURGERY **Date(s) of Service**

Type of Surgery	**From** (mm/dd/yyyy)	**To** (mm/dd/yyyy)	**Procedure Description Procedure Code**
Inpatient			
Outpatient			

DOCTOR'S INFORMATION:
Signature of doctor: X ____ Date (mm/dd/yyyy): ____/____/_______
Name of doctor: ______________________________ Phone: (_____)______________ Fax: (______)________________
Address: ____
Email address: ____ **Tax ID or SSN:** ___________________________

B. EMERGENCY ROOM, WELLNESS, AND/OR DIAGNOSTIC PROCEDURE BENEFITS. Please complete and attach itemized copies of any related bills including emergency room, hospital and/or ambulatory surgical center. Bills should include diagnosis information from your medical provider.

Diagnosis/ICD-9 Code(s): ____
Date(s) of treatment (mm/dd/yyyy):____/____/_____ - ____/____/_____
Hospital: ____ Phone Number: (_____)_______________________
Hospital Address: ____

DOCTOR'S INFORMATION:
Signature of doctor: X ____ Date (mm/dd/yyyy): ____/____/_______
Name of doctor: ______________________________ Phone: (_____)______________ Fax: (______)________________
Address: ____
Email address: ____ **Tax ID or SSN:** ___________________________

C. CANCER BENEFITS. See bottom of page 2. Please be sure to enclose a copy of the pathology report.

HOSPITALIZATION **Dates of Service**

Place of Confinement	**From** (mm/dd/yyyy)	**To** (mm/dd/yyyy)
Intensive Care Unit (Coronary, Sub-acute, etc.)		
Hospital (Private, Semi-Private, Other)		
Outpatient Surgery		

Diagnosis/ICD-9 Code(s): ____
Hospital: ____ Phone Number: (_____)_______________________
Hospital Address: ____

DOCTOR'S INFORMATION:
Signature of doctor: X ____ Date (mm/dd/yyyy): _____/_____/______
Name of doctor: ______________________________ Phone: (_____)______________ Fax: (______)________________
Address: ____
Email address: ____ **Tax ID or SSN:** ______________________

Authorization for Colonial Life

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information 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. Colonial Life will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, 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 and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life 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 revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

______________________	______________	______________________	______________
Printed name of individual	Social Security #	Signature	Date Signed

If applicable, I signed on behalf of the insured ______________________(indicate relationship).
If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

______________________	______________________	______________
Printed name of legal representative	Signature of legal representative	Date Signed

Claim 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.

Resident State	State Version of Fraud Warning
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 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	*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.
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.
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 containing any false, incomplete, or misleading information is guilty of a felony.
Indiana	Any 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 and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and 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.

Resident State	State Version of Fraud Warning
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.
Oregon	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
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.
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.