CRITICAL ILLNESS CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim. Please review your policy for specific benefits covered under your plan.

To prevent delays, please provide documentation from your healthcare provider to support this claim.

Several states require that the following statement appear on the claim forms:

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 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 have read the fraud notice included with this form.

Policyholder’s Signature: ___________________________ Date: ________________

Patient’s Signature: ___________________________ Date: ________________

Disclaimer: Some of the services listed may not be covered by your policy. Please sign the attached HIPAA Form and return it with the completed claim form.

• Please indicate the condition that the patient is filing for below:

☐ Cancer; Carcinoma in situ- Please submit a copy of the pathology report from which the condition was diagnosed.

☐ Heart Attack: Please submit a copy of the discharge summary, cardiology consult report, cardiac catheterization report, history & physical, and ER notes.

☐ Coronary Artery Bypass Surgery: Please submit a copy of the operative report for the procedure.

☐ Major Organ Transplant: Please submit a copy of the operative report for the procedure.

☐ Stroke: Please submit a copy of the discharge summary, MRI and/or CT test reports from the initial diagnosis, as well as proof of permanent neurological damage (i.e. follow up CT and/or MRI reports, office notes from neurologist or therapist, etc.)

☐ Renal Failure: Please submit proof of the start date for dialysis or the operative report for transplant. The End Stage Renal Disease Medical Evidence Report is preferred.

☐ Heart Event: Please submit a copy of the operative report for the procedure.

• Was death a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the death certificate and legal documents verifying the person authorized to handle the affairs of the deceased.)
# CRITICAL ILLNESS CLAIM FORM

## ATTENDING PHYSICIAN’S STATEMENT

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Attending Physician’s Name</th>
<th>Date of Birth</th>
<th>Date of Death (if Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When did signs and/or symptoms first appear?</td>
<td>Has the patient ever received medical advice or treatment for this or a similar condition? □ Yes, when __________________. □ No</td>
<td>Diagnosis (including complications)</td>
<td></td>
</tr>
</tbody>
</table>

## CANCER/CARCINOMA IN SITU

| Date of diagnosis (the date the pathological specimen(s) were obtained on which cancer or carcinoma in situ were diagnosed) | Was the cancer/carcinoma in situ □ Pathologically diagnosed, or □ Clinically diagnosed, or |

If the cancer/carcinoma in situ was pathologically diagnosed, attach a copy of the pathology report if the cancer/carcinoma in situ was clinically diagnosed, please provide the reason(s) that pathological diagnosis was not obtained and attach medical evidence that supports the diagnosis of cancer.

## MYOCARDIAL INFARCTION (HEART ATTACK)

| Does the patient’s condition meet all of the following criteria: | Yes □ No □ |
| 1. Are new and serial electrocardiographic (EKG) findings consistent with myocardial infarction? | Yes □ No □ |
| 2. Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine phosphokinase (CPK), a CPK-MB measurement must be used? | Yes □ No □ |
| 3. Did diagnostic studies confirm a myocardial infarction and the occlusion of one or more coronary arteries? | Yes □ No □ |
| 4. Did the patient have chest pain consistent with myocardial infarction? | Yes □ No □ |

Date of diagnosis (the date the patient met all of the above criteria for myocardial infarction)

## CORONARY ARTERY BYPASS SURGERY

| Did the patient undergo open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts? | Yes □ No □ |

What condition caused the need for coronary artery bypass surgery? When was the patient first treated for signs or symptoms of this condition?

## MAJOR ORGAN TRANSPLANT

| Did the patient undergo surgery to receive a human heart, liver, lung, kidney, or pancreas? | Yes □ No □ |

What condition caused the need for the major organ transplant? When was the patient first treated for signs or symptoms of this condition?

## STROKE

| Did the patient have a stroke, meaning apoplexy, secondary to rupture or acute occlusion of a cerebral artery? Stroke does not include transient ischemic attacks and attacks of vertebrobasilar ischemia, head injury, or chronic cerebrovascular insufficiency. | Yes □ No □ |

Did the patient’s stroke produce permanent clinical neurological sequelae persisting for more than 30 days following diagnosis? Yes □ No □

Date of diagnosis (the date a stroke occurred based on documented neurological deficits and neuroimaging studies)

## RENAL FAILURE

| Does the patient have end stage renal failure presenting as chronic, irreversible failure to function of both kidneys? | Yes □ No □ |

Does the patient’s kidney failure necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly) or which results in kidney transplantation? Yes □ No □

Date of diagnosis (the date a doctor or physician recommends that the patient begin renal dialysis)

What is the cause for the patient’s renal disease? When was the patient first treated for signs or symptoms of this condition?

## ATTENDING PHYSICIAN’S SIGNATURE

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

<table>
<thead>
<tr>
<th>Name (attending physician)</th>
<th>Degree</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Signature</td>
<td>Date</td>
<td>Medical ID#</td>
</tr>
</tbody>
</table>
AUTHORIZATION TO OBTAIN INFORMATION
CONTINENTAL AMERICAN INSURANCE COMPANY

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 for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history 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 any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or 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. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC 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 revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization 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.

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 Subject to Disclosure) (Date of Birth)

(Signature) (Date Signed)

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

(Printed Name of Legal Representative)

(Signature of Legal Representative) (Date Signed)