Please check the box next to your insurance company's name.

❑ Central United Life Insurance ❑ Investors Consolidated Insurance Company ❑ Loyal American Insurance Company ❑ Unum

EXPRESS CANCER SCREENING BENEFIT CLAIM FORM

◆ PATIENT AND INSURED INFORMATION ◆

PATIENT'S NAME | DATE OF BIRTH | POLICY NUMBER

ADDRESS | SOCIAL SECURITY NUMBER

POLICYHOLDER'S NAME | RELATIONSHIP TO POLICYHOLDER

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE authorize any release of any medical information necessary to process this claim, I require payment to myself or to the party who accepts assignments below. X_____ DATE_____		INSURED OR AUTHORIZED PERSON'S SIGNATURE I I certify that the foregoing statements are true and correct. I DO ❑ DO NOT ❑ authorize payment of medical benefits to undersigned physician or supplier of services described below. X_____ DATE_____

◆ PHYSICIAN OR PROVIDER INFORMATION ◆

Name And Address Of Facility Where Services Rendered			Your Patient Account No.	
Date of Service	Place of Service	Please place an X in the box beside the following tests performed	Diagnosis Code	Charges
		❑ Mammography		
		❑ Colonoscopy		
		❑ Flexible Sigmoidoscopy		
		❑ CA 125 (blood test ovarian cancer)		
		❑ Pap Smear (test only)		
		❑ Chest X-ray		
		❑ PSA (blood test for prostate cancer)		
		❑ Hemocult Stool Specimen		
		❑ Serum Protein Electrophoresis		

Signature Of Physician Or Provider
- NOT APPLICABLE IF BILL IS PROVIDED –

X

Physician's Or Supplier's Name, Address, Zip Code & Telephone No.

Physician's Phone No. | ID Number

1-800-669-9030

INSURANCE FRAUD WARNING

Any person who, with intent to injure, deceive, or defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of a felony of the third degree.

CSB 1-98

Claims Department
P. O. Box 925309
Houston, TX 77292-5309

Please check the box next to your insurance company's name.

❑ Central United Life Insurance ❑ Investors Consolidated Insurance Company ❑ Loyal American Insurance Company

REPORT OF CANCER OR SPECIFIED DISEASE CLAIM

PATIENT'S NAME	DATE OF BIRTH	POLICY NUMBER
ADDRESS		SOCIAL SECURITY NUMBER
POLICYHOLDER'S NAME		RELATIONSHIP to POLICYHOLDER
WHAT IS THE NATURE OF YOUR ILLNESS?	DATE DIAGNOSED	DATE OF FIRST TREATMENT
PHYSICIAN NAME AND ADDRESS		

WERE YOU HOSPITALIZED? YES ____ NO ____ DATE OF CONFINEMENT _____ THROUGH _____

NAME AND ADDRESS OF HOSPITAL _____

HAVE YOU EVER HAD A SIMILAR ILLNESS? YES ____ NO ____ IF SO, WHEN _____

I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by Central United Life, Investors Consolidated or Loyal American or their duly authorized representative to Central United Life, Investors Consolidated or Loyal American. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is valid for 24 months. Revocation of the authorization must be submitted in writing. I or my authorized representative is entitled to a copy of this authorization.

Date: _____ Signature of Insured: _____
Social Security #

Signature of Patient: _____
Required only if patient is spouse or over age 18

Address _____

City _____ State _____ Zip _____

Please send us the following information to us at the below address so we can process your claim:

- **Itemized statements from your health care providers showing the treatments, services and procedures you received,**
- **A pathology report for any surgical procedure,**
- **Documents showing the actual charges paid by you or on your behalf (such as Explanation of Benefit payment from your primary insurance carrier or Statement of Account from your health care provider.)**
- **If your policy has a transportation benefit, please submit a transportation claim form if you think you may be entitled to a transportation benefit.**

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Houston, TX 77292-5309

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MANHATTAN INSURANCE GROUP

IMPORTANT NOTICE REGARDING CANCER BENEFITS BASED ON ACTUAL CHARGES

In today's health care system, there is often a significant difference between the amount a provider may file as a claim with third-party payors or places on its statement for a service versus the amount the provider, in fact, reasonably expects to be paid at the time of service and is in fact paid for that service.

For example, a provider may generate a statement, claim form or computer print out (collectively, "statements") listing the services rendered along with a dollar amount for the service. If you have primary health insurance, your provider has typically entered into an agreement with your primary health insurer that specifies the amount the provider has agreed to accept and will be paid in full for its services. The amount the provider has agreed to accept in full payment is usually less than the amount the provider puts on its statement or transmits as a claim to your primary health insurer.

Similarly, where Medicare is involved, the amount the provider can charge a health care provider is set by law. The Medicare approved amount a provider can be paid in full for services is often less than the amount shown in the provider's statement or submitted as a claim to Medicare. Additionally, you personally may have requested and received a reduction in the amount the provider has agreed to accept as payment in full.

In all of these cases, the amounts shown on the provider's claim form or statement is not the real amount the provider, in fact, charged for the service and was paid for the service. The actual charge instead will be reflected in an Explanation of Benefits (EOB) from your primary insurance company, in a Medicare Summary if you are on Medicare, or other similar documentation provided to you by the provider showing adjustments to the provider's list price for the service.

In those instances where the benefit amount under your supplemental cancer policy for radiation, chemotherapy and blood benefits are based upon the actual charge and is not subject to a cap, we determine the amount of benefits based upon the amount that the provider has, in fact, charged: that is, the real amount the provider has accepted as full payment by you or on your behalf for the service rendered.

Here's what you can do to expedite the processing of your claim: When making a claim for a benefit that is based on the actual charge for a service, please supply us with documentation reflecting the amount paid to, and accepted by, the provider for the service. This will enable us to determine the amount that was paid by you or on your behalf for covered services and accepted by the provider as payment in full for these services. This information would include, for example, any Explanation of Benefit statements, Medicare Summary, or statements of account showing the amounts the health care providers were paid by you or on your behalf.

Please call us at 1-800-669-9030 if you have any questions. We appreciate your business.

How to File a Cancer Claim

To assist us in trying to consider your cancer claim, please read the section below and follow these helpful guidelines. If you have any questions, please do not hesitate to contact our Customer Service Department at 1-800-669-9030.

1. Please read your policy closely. Cancer policies provide benefits for certain specified treatments, procedures and services rendered to the policyholder for the treatment of cancer. These limited benefit policies pay benefits only for those items listed in your policy. Since the cancer policy is a specified benefits policy, it does not pay for all treatments, procedures or services you may receive in connection with your cancer treatment.

2. Please complete the claim form in its entirety. It is your responsibility to provide us with all of the information, including medical records, needed to determine if you are entitled to be paid for any of the specified benefits under the policy so we can process your claim.

3. Please always include your policy number on the claim form and indicate if you have more than one policy with us. Please include your area code along with the telephone number for yourself, your physician or employer.

4. Attach all relevant information to your claim form, i.e. itemized statements, computer print outs, hospital claim forms, etc from each medical provider who treated you. These statements should provide detailed information regarding the treatments, procedures and services you received from the medical provider. The statements should also include the provider's name, address, telephone number and tax identification number. Please attach prescription receipts showing the name of the drug, drug number, date of service and the amount paid (cash register or charge slips are not acceptable).

5. If your cancer policy contains any benefits that are based on actual charge for a particular treatment (most commonly chemotherapy/radiation and blood/plasma benefits), please submit documentation showing the amount the medical provider actually charged – that is, the amount the medical provider was paid in full . Documents showing the amount the medical provider was paid in full include usually include itemized statements from your medical provider or the Explanation of Benefits from your primary insurance carrier showing the amount the insurance carrier paid the medical provider for the covered treatments, procedures or services..

6. Upon the initial diagnosis of cancer, please submit a pathology report. A pathology report showing a positive diagnosis of cancer is needed before any cancer benefits can be processed.

7. SURGERY/ANESTHESIA: When submitting a claim for surgery performed to remover cancer, please provide a copy of the surgeon's statement and the anesthesiology statement with your completed claim form. In addition, a pathology report should be submitted with any surgical claim.

8. TRANSPORTATION: If your policy has a transportation benefit provision and you had to travel from your home to obtain cancer treatment, please complete the transportation claim form (separate from the Cancer Claim form) if you want to make a claim for the transportation benefit... Make sure you attach the appropriate receipts/documentation as indicated on the claim form.

In the event you do not submit the required documentation with your claim, we will contact you to request that you provide us with needed information.

Thank you for taking the time to read these instructions.