MEDICAL ILLNESS CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

PLEASE READ BEFORE COMPLETING THIS FORM

The furnishing of this form is for the convenience of the policyholder and is not an acknowledgement of liability or waiver of any right.

INSTRUCTIONS:

1. Complete Policyholder/Patient Information on this page.
2. Be sure to sign your claim form at the bottom of this page.
3. **If you are filing for disability**, please complete the "Individual Disability Notice of Claim" form.

ADDITIONAL NOTES:

1. Submit all bills related to this claim such as doctor, hospital (must include the number of days confined, if applicable), ambulance, follow-up visits, physical therapy, etc. All bills should be itemized and should include the diagnosis, services rendered, date of service and actual charges for the service.
2. Be sure to include your policy number on all documents.
3. Provide list of physicians seen in last 2 years.
4. Complete HIPAA form

POLICYHOLDER'S INFORMATION

Policyholder Name (Last, first, middle initial)		Policy Number
Address (City, State, Zip Code)	❑Check This Box If This A New Permanent Address	
Social Security Number	Date of Birth	Telephone Number

PATIENT'S INFORMATION

Patient Name (Last, First, Middle Initial)		Social Security Number	Date of Birth	Height and Weight
❑ Male ❑ Female	❑Single ❑ Other ❑Married	Relationship:	❑ Self ❑ Dependent ❑ Spouse ❑ Check if dependent is full-time student	
*If the patient (child) is over age 19 and a full-time student, provide the name of the school being attended:		School's Address _____		

***If you have not previously submitted proof of full-time student status for the period of the medical expenses submitted, you must do so before the claim can be processed.**

What illness was suffered?		On what date did you first notice you were beginning to get sick? (MM/DD/YYYY) ❑ AM ❑ PM	
Have you ever had the same illness before? ❑ Yes ❑ No	If YES, when? (MM/DD/YYYY)	Date you were first treated by a physician for the illness? (MM/DD/YYYY)	
Were you hospitalized? ** ❑ Yes ❑ No	If YES, on what date were you admitted? (MM/DD/YYYY)	On what date were you released? (MM/DD/YYYY)	
Have you had any medical or surgical advice during the past 5 years for any other condition? ❑Yes ❑ No	If YES, for what?	When? (MM/DD/YYYY)	
Physician's Name and Address			
Has any other physician treated you for this illness? ❑ Yes ❑ No	When? (MM/DD/YYYY)		
Physician's Name and Address			

**If you were in the hospital, please attach an itemized statement.

I authorize any hospital, physician, or other person who has attended me or examined me to disclose to my insurer or their duly authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment relative to my person, and to furnish copies of all hospital or medical records. 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. I understand and agree and if payment of benefits to me results in an overpayment, the Company may deduct the amount of the overpayment from future benefit payments.

_____ _____

Signature (If Claim Is For A Minor, Parent Or Legal Guardian Must Sign) Date

Submit Completed Form to:
Claims Department
P.O. Box 925309
Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
manhattanlife.com

MEDILL 0317

ManhattanLife™

Manhattan Life Insurance Company
Family Life Insurance Company
Western United Life Assurance Company
ManhattanLife Insurance and Annuity Company

Claims Department
P.O. Box 924408
Houston, Texas 77292-4408

Authorization to Obtain and Disclose Protected Health Information and Other Information

Name: _____ Policy No: _____

Date of Birth_____

I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to the Company(ies) identified above, hereinafter called the Company including any legal representative designated by the Company, the following protected health information: Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to the Company and any legal representative that it might designate.

I authorize the Company to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of the Company or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, the Company pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to the Company at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____ _____

Date Authorization Signed

Signature of Claimant or Authorized Personal Representative
(e.g., parent or guardian, if minor)

10777 Northwest Freeway
Suite 600
Houston, TX 77092

Toll Free: 800-879-6542
www.manhattanlife.com