# Hospital Indemnity & Supplemental Health Claim Form

ManhattanLife

**Insured Statement**

**The claimant is the:** ☐ Policyholder ☐ Dependent

Policyholder's Name_____ Policy No._____
(If this is a name change, provide a copy of an updated driver's license, government issued ID, marriage license or divorce decree.)

Date of Birth_____ Mailing Address_____

City_____ State_____ZIP Code_____

Phone No._____

Claimant Name_____ Date of Birth_____

Review items 1 - 3 below to ensure complete and accurate documents are submitted along with this claim form. **The below benefits may not apply to all hospital indemnity or supplemental health policies, review your Certificate for specific benefit eligibility.**

1. If filing for medical services rendered due to injuries **as a result of an accident** complete the below information. **If it is not due to an accident, move to item two.**

   Date of accident_____First date of treatment for injury_____

   Where and how did the accident occur:_____

   _____

   Describe the injury(s):_____

   Did the accident occur at work: ☐ Yes ☐ No If yes, was the employer informed: ☐ Yes ☐ No
   Employer Name_____
   Address_____ Phone No._____

   Have you filed a Workers' Compensation or Occupational Disease Law Claim: ☐ Yes ☐ No

   **Submit the following documents when filing for an accidental injury:** Completed claim form, itemized provider bill (HCFA1500) and/or hospital bills (UBO4) which include all dates of services, diagnosis, and procedure/revenue codes.

2. If filing for medical services rendered **due to an illness, pregnancy, or routine care** provide the following: Completed claim form, itemized provider bill (HCFA1500) and/or hospital bills (UBO4) which include all dates of services, diagnosis, and procedure codes.

3. If filing for any of the below travel expenses, include travel receipts along with the claim form.
   - **Lodging for the claimant**
   - **Lodging for a friend or family member**
   - **Transportation**

# Hospital Indemnity & Supplemental Health Claim Form

Review the conditions listed below. Enclose the requested documentation listed within the Required Documentation section for the condition the claimant is being treated for. **All diagnosis must occur after the policy effective date.**

| Tier 1 | Required Documentation |
|---|---|
| **Chronic Kidney Disease** | Medical records from treating physician. |
| **Benign Brain Tumor** | Medical records from treating physician. |
| **Carcinoma in Situ** | Medical records from treating physician. |
| **Guillain – Barre** | Medical records from treating physician. |
| **West Nile Virus** | Medical records from treating physician. |

| Tier 2 | Required Documentation |
|---|---|
| **Alzheimer's Disease** | Medical records from treating physician or neurologist. |
| **Benign Brain Tumor** | Medical records from treating physician |
| **Carcinoma in Situ** | Medical records from treating physician |
| **Guillain – Barre** | Medical records from treating physician |

| Tier 3 | Required Documentation |
|---|---|
| **Invasive Cancer** | Medical records from treating oncologist. |
| **End Stage Renal Disease** | Medical records from nephrologist and proof of renal dialysis. |
| **Loss of Sight** | Medical records from treating ophthalmologist. |
| **Loss of Speech** | Medical records from treating speech pathologist. |
| **Loss of Hearing** | Medical records from treating audiologist. |
| **Coma** | Medical records from neurologist. |
| **Severe Burns** | Medical records from treating plastic surgeon. |
| **Occupational HIV** | Medical records from treating physician. |
| **Permanent Paralysis from an Accident** | Medical records from treating physician. |
| **Major Organ Transplant** | Medical records from treating physician. |
| **Stroke** | Medical records from neurologist. |
| **Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's)** | Medical records from neurologist. |
| **Multiple Sclerosis** | Medical records from treating physician. |
| **Heart Attack** | Medical records from treating cardiologist. |
| | |

# Hospital Indemnity & Supplemental Health Claim Form

ManhattanLife

| Child Major Conditions | Required Documentation |
|---|---|
| **Down Syndrome** | Medical records from treating physician. |
| **Juvenile Diabetes (Type 1)** | Medical records from treating physician. |
| **Cerebral Palsy** | Medical records from treating physician. |
| **Cleft Palate** | Medical records from treating physician. |
| **Cystic Fibrosis** | Medical records from treating physician. |
| **Spina Bifida** | Medical records from treating physician. |

Any Person, who with the intent to defraud or knowing that they are facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive statements may be submit to prosecution and punishment for insurance fraud.
(See State Specific Fraud Warning Statements on page 7)
**The statements on page one are true to the best of my knowledge and belief.**

Signature of Policyholder _____ Date _____

**If the claim is being filed for services within the first two years of the policy, complete the physician and medication information below:**

## Physician information

List all physicians that treated the claimant in the five years prior to the policy effective date.

| Physician's Name | Address | Phone No. | Reason for Visit |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Medication information

List all medications being taken by the claimant:

| Medication | Prescribing Physician | Date Prescribed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# Direct Deposit Authorization

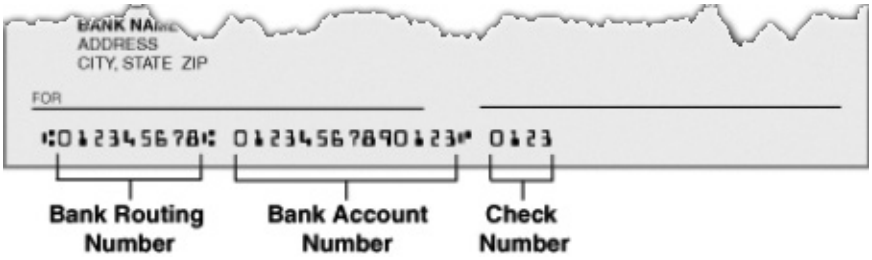
ManhattanLife™

| Check Action | | | Account Type | | Ownership of Account | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| New | Change | Cancel | Checking | Savings | Self | Other |

Bank Name_____

Bank Routing Number_____ Bank Account Number_____

Policy Holder's Name _____ Policy Number _____




**Terms and Conditions For Annuitants Participating In The Direct Deposit Program**

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program, please read the following terms and conditions for participation carefully before making your decision. Not all polices may qualify.

1. Once the Form is received by ManhattanLife, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify ManhattanLife of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be canceled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to ManhattanLife or cannot be made to your account, ManhattanLife will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be canceled by your financial institution or ManhattanLife. **Your participation will be canceled automatically if you terminate participation in the above Account(s).**

I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize ManhattanLife to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____ _____ _____

Signature Printed Name Date

**Authorization to Release Information**
For the Use and Disclosure of Protected Health Information


**Patient's Name**_____**Policy No.** _____

**Patient's Date of Birth** _____

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

**I authorize the use and/or disclosure of my protected health information and other related information as described below:**

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals to disclose my protected health information to ManhattanLife,
3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
5. I authorize only designated staff of ManhattanLife to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Attn: Claims Department PO Box 926169 Houston, TX 77292 . This revocation shall become effective on the date it is received by ManhattanLife. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

_____ _____ _____
*Signature* *Printed Name* *Date*

I have legal authority* under the laws of the State of_____to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies and execute this Authorization in my capacity as Authorized Representative thereof.

_____ _____ _____
*Name of Authorized Representative/Parent or Guardian* *Relationship to Applicant* *Date*

**A copy of the legal authority document must be on file with ManhattanLife.*

# Hospital Indemnity & Supplemental Health Claim Form

ManhattanLife

## Treating Physician Statement

### Patient Information:

Patient Name _____ Policy No. _____

Date of Birth _____ Address _____

City _____ State _____ ZIP Code _____

### Treatment Information

Diagnosis (include any complications) _____

ICD -9/ICD – 10 Code(s) _____

Date the symptoms first appeared: _____ Date of first visit: _____

Date of definitive diagnosis: _____ Date of surgery(CABG): _____

Has the patient been treated for this same or a similar condition prior to this occurrence? ☐ Yes ☐ No
If yes, list the date(s) of prior treatment _____

Was this patient referred to you? ☐ Yes ☐ No
If yes, provide the referring physician information below:

Referring Physician Name _____ Phone No. _____
Referring Physician Address _____

Any Person, who with the intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 7)

***The above Statements are true to the best of my knowledge and belief.***

Printed name of Treating Physician _____ Phone No. _____

Specialty _____ Street Address _____

City _____ State _____ ZIP Code _____

_____ _____

Signature of Treating Physician Date

**Claim Form Addendum: 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.

**Alabama** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **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 information to obtain or amend insurance coverage or to make a 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. **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. **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. **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 of claim containing any false, incomplete, or misleading information is guilty of a felony. **Indiana** A 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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. **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. **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 by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be 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. **Rhode Island** 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. **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.