VB Facility Care Accelerated Living Benefit Claim Form

This claim form should be used with the intents and purposes of filing a claim for an accelerating living benefit in which the insured has been diagnosed with a chronic illness and is continually confined to a nursing home, assisted living facility, is receiving home health care or adult day care services.

Employee Information:

Policy Holder's Name_____ Policy No. _____

Date of Birth _____ Mailing Address_____

City_____ State_____ ZIP Code_____

Daytime Phone No. _____

Employer's Name_____

Street Address_____ City _____

State_____ ZIP Code_____ Phone No._____

Occupation _____

Claim Information:

Date of the first symptoms of the chronic illness_____

Date you were first treated _____

Physician Information: *Attending or Treating Physicians*

Physician's Name	Address	Telephone & Fax Number

Facility Care: Complete all information below and submit an itemized bill for the services being claimed. The itemized bill must include diagnosis and procedure codes.

☐ Nursing Home

☐ Assisted Living

Dates of Service:_____ To_____

Facility Name_____

Street Address_____ City_____

State_____ ZIP Code_____ Phone No._____

Home Care: Complete all information below and submit an itemized bill for the services being claimed. The itemized bill must include diagnosis and procedure codes.

☐ Home Health Care

☐ Adult Day Care

Dates of Service_____To_____

Agency Name_____

Street Address_____City_____

State _____ ZIP Code_____Phone No._____

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing false or deceptive statement(s) 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.

_____ _____

Signature of Policy Holder Date

STOP

- Submit the Employee and Physician statements to prevent delays in processing. All sections are required before the Accelerated Living Benefit claim can be reviewed.
- Sign and date the authorization on page 4 and include with claim submission
- Submit the billing invoices for the facility or agency, which include the diagnosis and procedure codes.

Direct Deposit Authorization

ManhattanLife™

Check Action **Account Type** **Ownership of Account**

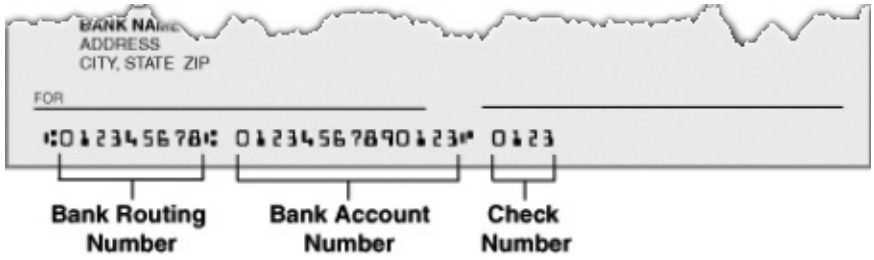
☐ New ☐ Change ☐ Cancel ☐ Checking ☐ Savings ☐ Self ☐ Other

Policy Holder's Name_____ Policy Number_____

Bank Name_____

Bank Routing Number_____ Bank Account Number_____

Account Holder's Name _____



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 _____

Mail to: ManhattanLife VB Claims
PO Box 926169
Houston TX 77292

Customer Care: 1-855-448-6982
Fax: 1-502-405-7107
Email: vbclaimssubmissions@manhattanlife.com

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

ManhattanLife™

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.*

VB Facility Care Accelerated Living Benefit Claim Form – Employee Statement

Benefit Agreement – Employee

For the value received, the receipt of which is hereby acknowledged, I, the undersigned, as the member, do hereby agree to the payment up to the full amount of the life insurance benefit in force on the life of the member as an Accelerated Benefit. I do hereby release all of my right, title and interest to this payment of the life insurance in force and do acknowledge that at the time of the payment of the life insurance as a claim due to the death of the member, the life insurance amount will be reduced by said Accelerated Benefit.

In consideration of the ManhattanLife payment to me of the Accelerated Benefit, I, the member, do hereby release, discharge and hold ManhattanLife and its affiliates and subsidiaries, their agents, officers, directors, and employees, harmless from any and all claims, demands, or causes of action which might arise out of ManhattanLife payment including indemnification against any awards, judgments or settlements, including litigation costs and attorney fees.

Payment from an Accelerated Benefit may be taxable. Assistance should be sought from your personal tax advisor. ManhattanLife is not responsible for any tax or other effects from an Accelerate Payment or loss of eligibility for any State or Federal Program.

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

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____

Signature Printed Name Date

Release of Benefit Agreement – Irrevocable Beneficiary or Irrevocable Assignment

I, , Irrevocable Beneficiary or Irrevocable Assignor designated for policy number _____ insuring the Life of _____, do hereby surrender rights up to the full benefit of the life insurance benefit to be paid to _____ as an Accelerated Living Benefit. I release ManhattanLife from all claims to this benefit that I may have as the Irrevocable Beneficiary or the Irrevocable Assignor.

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____

Signature of Irrevocable Beneficiary or Irrevocable Assignor Printed Name Date

VB Facility Care Accelerated Living Benefit Claim Form – Treating Physician Statement

Patient Information:

Patient's Name_____ Date of Birth_____

Is this condition due to an injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown

Treatment Information:

Diagnosis include any complications_____

Date of patient's first visit for this condition_____ Date of last patient visit_____

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other(specify)

If the patient is confined to a Nursing Home or Assisted Living Facility:

Date of admission_____

Date of discharge(if applicable)_____

If the patient is receiving Home Health Care or Adult Daycare Services:

Date of patient's first visit_____

Date of patient's last visit_____

Frequency of visits ☐ Weekly ☐ Monthly ☐ Other(specify)

Impairment:

Is your patient capable of performing the following activities of daily living independently?

Bathing	☐ Yes	☐ No
Dressing	☐ Yes	☐ No
Continence/Toileting	☐ Yes	☐ No
Eating	☐ Yes	☐ No
Transferring	☐ Yes	☐ No

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing false or deceptive statement(s) 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 Physician_____ Phone No._____

Specialty_____ Street Address_____

City_____State_____ZIP Code_____

_____ _____

Signature of 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.