Underwritten by:

ManhattanLife Insurance & Annuity Company
Standard Life & Casualty Company

SHORT TERM CARE CLAIM FORM and Optional Rider CLAIM FORM

Please read the important information below:

☐ This packet is used for filing your Short-Term Care benefit and optional rider claims. Please be sure your policy number(s) is/are on all documents.

☐ The claim form should be completed and signed by the Insured or responsible party. **Please attach Power of Attorney or Guardian papers if applicable.**

☐ The **HIPAA Authorization** to Permit Use and Disclosure of Health Information must be signed, dated and included with your submission, so that we can contact your medical provider on your behalf for additional information needed.

☐ The **Physicians Certification** form must be completed by the ordering physician.

☐ Include any **itemized bills** for consideration. We do not pay on any advanced billing. Include any Aide note(s) for your care. Please be sure you answer ALL questions on the claim form.

An itemized bill should contain:

1. The date(s) of treatment,
2. The type(s) of service,
3. The diagnosis,
4. The medical provider's name and address,
5. The individual charge for each expense.

☐ **If you are filing only for your Prescription Drug Benefits, please use just the Prescription Drug Filing Form** provided on the website, as all these additional forms and information are not required.

☐ Please send all information to:

ManhattanLife Insurance & Annuity Company
P.O. Box 925568
Houston, TX 77292
Fax to: (713) 583-2738

NOTE: Your Policy may have a Pre-Existing Conditions Limitation and a 3 Year Policy Contestability Period. If your claim happened during one of these periods, additional information may be required. If we need to request any additional information and we have your signed HIPAA Authorization, we will handle these requests directly with your medical provider(s) and will notify you of our action and any delays.

If you signed a benefits assignment with the provider and you have a balance still due, we are required to pay that balance directly to them; otherwise, benefits will be sent to you.

- **Processing delays may result if you do not provide all the above information.**
- We suggest you make photocopies of any information sent for your own records.

For assistance, please contact our Customer Service Department (800) 672-4535

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SHORT-TERM CARE CLAIM FORM and Optional Rider CLAIM FORM

TO BE COMPLETED BY THE INSURED

Policyholder's Name			Date of Birth	
Policy Number(s)				
Address	(Street)	(City)	(State)	(Zip Code)
Phone		Email		

TYPE OF BENEFIT(S) FOR WHICH THE CLAIM IS BEING MADE

☐ **Daily Benefit (Facility Care):**

- ☐ Nursing Facility
- ☐ Assisted Living Facility
- ☐ Hospice Care
- ☐ Bed Reservation

☐ **Check here if you elect to use the "Fast-50 Facility Care Benefit**

(Note: If you elect to receive the Fast-50 Facility Care Benefit, we will pay fifty percent (50%) of your per day Facility Care Benefit amount shown on the policy schedule. The elimination period for the Facility Care Benefit, if any, is waived if you elect to receive this benefit. If you are eligible for the Facility Care Benefit and elect the Fast-50, we will pay the Fast-50 Benefit for each day you meet the coverage requirements. If you switch from the Fast-50 to the Facility Care Benefit, you must still satisfy the elimination period.)

☐ **Home Health Rider:**

- ☐ Skilled Nursing Care–provided by an RN
- ☐ Chemotherapy Specialist Services
- ☐ General Nursing Care–provided by an LPN, LVN, or licensed visiting nurse
- ☐ Enterostomal Therapy
- ☐ Home Health Care Aide Benefit
- ☐ Respiration Therapy
- ☐ Speech Pathology
- ☐ Medical Social Services
- ☐ Occupational Therapy
- ☐ Physical Therapy

☐ **Hospital Indemnity Rider:**

Date Range of Hospitalization:
Reason for Hospitalization:

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SHORT-TERM CARE CLAIM FORM and Optional Rider CLAIM FORM

Date symptoms first appeared: ______________________ Date of first visit with physician? ________________________

Date of actual/definitive diagnosis:

Have you ever had this illness/condition before? ☐ Yes ☐ No If yes, date? ______________________

If yes, what's the name, address, and telephone number of physician? ____

If hospitalized for this illness/condition, what's the name and address of hospital/medical center? ____________________

Are you now, or have you received home health care services before? If yes, when: ______________________

What condition were/are you receiving care for? ____

Have you ever been diagnosed with a cognitive illness? What diagnosis: ______________________When: ___________

Your Primary Care (family doctor) name, address, and telephone number: ____

Were there any OTHER PHYSICIANS seen during the last two (2) years? *(if more space is needed, please attach separate sheet)*
If so, please provide their names, addresses and phone numbers:

____

Physician name type of doctor address and phone number

____

Physician name type of doctor address and phone number

I understand that this information will be used by ManhattanLife Insurance & Annuity Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of the authorization upon request.

Insured's Signature: ________________________ Print Name: ____________________________Date: __________

STCFORM 6/23

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PHYSICIAN'S HEALTH CERTIFICATION

Policy No.	Certification Period From: To:
Patient's Name and Address	Physician's Name and Address
	Physician's Tax I.D. No.
Date of Birth: Sex: ☐ M ☐ F	

ICD-9-CM	Principal Diagnosis	Date	Hospital Confinement for which Subsequent Home Health Care was needed: A. From: To: B. Name of Hospital and Address
ICD-9-CM	Other Pertinent Diagnosis	Date	

Can the patient perform any of the following Activities of Daily Living (AOL's) without the assistance of another person?

YES	NO	
☐	☐	Bathing (getting in and out of the bathtub or shower, utilizing normal bathroom facilities that have been equipped with railings and steps
☐	☐	Dressing (tying shoes, buttoning buttons or clasps)
☐	☐	Eating (consuming food or drink or utilizing utensils, appropriate for the patient's physical condition and which are placed within reach)
☐	☐	Toileting (maintaining adequate bathroom hygiene and toilet habits)
☐	☐	Transferring to or from bed or chair

Does the patient require continuous supervision & assistance due to a Cognitive Impairment (a deficiency in the ability to think, perceive, reason, and/or remember, which has been evaluated and measured through clinical evidence and standardized tests)?

Home Healthcare Services Performed:

☐ Skilled Nursing (RN)	☐ Occupational Therapy
☐ General Nursing (LPN/LVN)	☐ Chemo Specialist Services
☐ Physical Therapy	☐ Enterostomal Therapy
☐ Speech Pathology	☐ Respiration Therapy
☐ Home Health Care Aide (Any individual, other than a member of the patient's immediate family, working under the supervision of an RN, who is qualified, by training and experience, to aide with the Activities of Daily Living and has been certified by the appropriate regulatory authority)	☐ Medical Social Services
☐ Other (Specify):	

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PHYSICIAN'S HEALTH CERTIFICATION

Other Remarks:	
I □ Certify that the above statements are true and correct and are based on standard medical tests I have performed and that the above home health services were/are required during the period of certification.	
Certifying Physician's Signature	Date Signed

Important Information

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that related to this diagnosis other than the documentation defined, please submit them for review. Failure to complete all sections may result in a delay in processing this claim.

For information or to check claim status, call 1-800-672-4535.

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HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by MIAC for the purpose of obtaining information necessary to process a claim for benefits.

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 regarding 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

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.