

# Critical Illness Claim Form

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

ManhattanLife Insurance and Annuity Company    Manhattan Life

## CLAIM AND RELATED DETAILS – TO BE COMPLETED BY THE INSURED

Name of Insured	Group Policy Number	Daytime Telephone Number
Address (Street, City, State, ZIP Code)		
Type of Critical Illness: <input type="checkbox"/> Cancer <input type="checkbox"/> Coronary Artery Bypass <input type="checkbox"/> Heart Attack/MI <input type="checkbox"/> Major Organ Transplant <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Renal Failure <input type="checkbox"/> Stroke/CVA	Date of Diagnosis/Surgery (M/D/Y):	
Name of Dependent (If applicable)	Dependent's Social Security Number	

On what date did you first notice your symptoms or medical problems that initiated the investigation leading to the diagnosis or surgery?

Give a brief description of your initial symptoms/medical problems.

On what date did you first consult a doctor or medical facility in connection with your illness?	Name of doctor first consulted
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Name, address and phone number of the doctor who made the diagnosis of your illness, or performed the surgery.

Have you undergone any test or investigations related to the diagnosis?   Yes   No   If **YES**, please provide details and dates:

Have you previously suffered from, or received treatment for, a similar or related illness?   Yes   No   If **YES**, please give details, including dates.

Please provide the Name, Address and Phone Number of your personal physician

Please provide details of any other doctors or specialists who have been consulted in connection with your illness. (Attach a separate sheet if additional space is needed)

Name	Address/Phone No.	Date Seen

If you have been treated at a hospital or institution, please supply the following information:

Name	Address/Phone No.	Date of Admission & Discharge

What other treatment have you received and are you currently receiving in connection with your illness (e.g. medications, therapy, etc)?

Type of Treatment	Institution/Prescribing Physician	Dates

Has any blood relative suffered from a similar or related illness?    Yes    No   If **YES**, please indicate:

Relationship	Nature of Illness	Age at which illness was first diagnosed

Provide details of any other insurance coverage under which an insurance benefit may be awarded for your condition. Also, please include any Workman's Compensation and Social Security Disability benefits.

Name of Insurer	Policy No.	Type of Benefit	Has a claim been filed?	Approved/Denied/Pending

Do you smoke or use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>YES</b> , please indicate amount per day	How long have you used tobacco?	If <b>NO</b> , did you previously use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No On what date did you quit?
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Please provide any further information that may be relevant to the claim:

I, the person insured, and/or the claim any if other than the insured, certify the above statements are true, accurate and complete to the best of my knowledge and belief. I understand that by furnishing this form and investigating the claim or by accepting proofs of claim, ManhattanLife Insurance and Annuity Company shall not be held to admit the validity of any claim nor the have waived any of its rights in defense of any claim arising under the policy/(ies).

Signature of Employee	Date	Signature of Dependent (if applicable)	Date
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**Submit Completed Form to:** Claims Department, P.O. Box 925309, Houston, TX 77292-5309  
Customer Service Department 1-800-669-9030  
www.manhattanlife.com



**ATTENDING PHYSICIAN'S STATEMENT - CRITICAL ILLNESS CLAIM**

**Important: The claimant is responsible for any fee for this information.**

**TO BE COMPLETED BY THE PHYSICIAN - Please complete form in its entirety.**

Your Patient (our insured)	Date of Birth	ManhattanLife Insurance and Annuity Policy Number(s)
Name of Owner (if other than person insured)		
Type of Critical Illness: <input type="checkbox"/> Cancer <input type="checkbox"/> Coronary Artery Bypass <input type="checkbox"/> Heart Attack/MI <input type="checkbox"/> Major Organ Transplant <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Renal Failure <input type="checkbox"/> Stroke/CVA		
How long has this person been your patient?	On what date did your patient first have symptoms, signs or evidence of the disease?	On what date did your patient first consult you for these symptoms/signs?
What were the symptoms/signs? Provide details and dates. <hr/> <hr/> <hr/>		
Was the diagnosis made by you? <input type="checkbox"/> Yes <input type="checkbox"/> No	If <b>NO</b> , please provide the name and address of the doctor who made the diagnosis	
Please provide the diagnosis, including all relevent details. <hr/> <hr/> <hr/>		
Please record the clinical course and exacerbations giving dates and duration. <hr/> <hr/> <hr/>		
Please give brief details of the treatments, procedures, or services performed including dates. Attach any records, reports, or documents which will assist in processing the claim. <hr/> <hr/> <hr/>		
Does the patient have a family history, or any predisposing illness/disorder or risk factors that increased the underlying risk of the illness/disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names and addresses of other physicians consulted by your patient for this condition.		
Name	Address (if known)	
<hr/> <hr/> <hr/>		
Please provide any other information that would be helpful in the assessment of your patient's Critical Illness claim. <hr/> <hr/> <hr/>		

Thank you for your time in completing this form. Date \_\_\_\_\_

\_\_\_\_\_  
Doctor's name (Print) Doctor's Signature Specialty

\_\_\_\_\_  
Telephone Number Complete Address (Street, City, State, ZIP Code)

**Please complete and return this form with all medical records that were requested to the address listed below.**

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



### 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.