Hospital Indemnity/Supplemental health/Healthcare Plus claim form

Section I – Member Information

Is the claim for the: ☐ Policyholder ☐ Dependent

Policyholder's Name _____ Policy No. _____

Mailing Address _____ Social Security No. _____

City _____ State _____ ZIP Code _____ Date of Birth ____/____/____

Daytime Telephone No. (____) _____

Claimant Name _____ Date of Birth ____/____/____

Section II – Condition Details

Type of services for which the claim is being made:

☐ Routine/Preventative Care ☐ Illness or Non-routine care ☐ Injury or Accident*

*If Injury or Accident please provide details below

Date of Accident ____/____/____ First date treated for injury ____/____/____

Please provide specific details of how your accident occurred:

Type of Injury:

_____

_____

Where did the accident occur:

_____

_____

How did the accident occur:

_____

_____

Did this accident occur at work? ☐ Yes ☐ No If yes, did you inform your employer? ☐ Yes ☐ No

Reported to: Employer Name _____

Address _____ Telephone No. (____) _____

Have you or do you intend to file Workers' Compensation or Occupational Disease Law Claim? ☐ 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 a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 4 and 5)

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

_____ ____/____/____

Signature of Policyholder Date

ManhattanLife Since 1850

Mail to ManhattanLife
Attn: Claims Department
PO Box 926169
Houston, TX 77092

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

Hospital Indemnity/Supplemental health/Healthcare Plus claim form

Authorization to release information - For the Use and Disclosure of Protected Health Information

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 Assurance Company of America, Manhattan Life Insurance Company.
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 Assurance Company of America, Manhattan Life Insurance Company, 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 Assurance Company of America, Manhattan Life Insurance Company P.O. Box 926169, Houston TX 77092. This revocation shall become effective on the date it is received by ManhattanLife Assurance Company of America, Manhattan Life Insurance Company. 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.

I certify that I have received a copy of this Authorization and authorize the use and/or disclosure of my protected health information as contemplated herein for ☐ all records or ☐ records for dates of service _____ to _____

_____	_____	____/____/____
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. If you have any questions when completing this form, please call 1-855-448-6982.*

Hospital Indemnity/Supplemental health/Healthcare Plus claim form

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

Physician information:

List all physicians that treated the patient in the five years prior to the policy effective date:

Physician's Name	Address	Phone Number	Reason for Visit

Medication information

List all medication being taken by the patient:

Medication	Prescribing Physician	Date Prescribed

Hospital Indemnity/Supplemental health/Healthcare Plus claim form

Travel Expenses:

Please check the type of travel benefit you are claiming for:

☐ Use of Personal Vehicle ☐ Lodging

Please check who accompanied you for your accident treatment:

☐ Attended Alone ☐ Spouse or Friend ☐ Child ☐ Multiple Adults and Children

- **Any claims submitted for reimbursement must include date of service, diagnosis and procedure codes**

State Specific Fraud Warning Statements

ManhattanLife:

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:

Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

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.

Arkansas, Louisiana, 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.

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 statement to appear on this form: Any person who knowingly presents 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.

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

Hospital Indemnity/Supplemental health/Healthcare Plus claim form

State Specific Fraud Warning Statements

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.

Kentucky, 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.

Kansas:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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.

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 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 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.

Virginia:

Any person who, with the 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 may have violated the state law.

Tiers 1, 2 & 3/Child Major Condition Form – Attending (Treating) Physician Statement

Patient Information:

Patient's Name_____ Policy No._____

Street Address_____ Date of Birth_____/_____/_____

City_____ State_____ ZIP Code _____

Treatment Information:

Please **check** appropriate box for each condition below for which you are treating this patient, and enclose the information listed under the Medical Documentation Requirements section.

Tiers	Medical Documentation Requirements
Tier 1	
☐ Chronic Kidney Disease	• Medical records from the Attending Physician showing proof of damage to the kidney
☐ Benign Brain Tumor	• Pathological or clinical diagnosis
☐ Carcinoma in Situ	• Pathological or Clinical Diagnosis
☐ Guillain-Barre	• Clinical and Laboratory diagnosis
☐ West Nile Virus	• Clinical and Laboratory diagnosis
Tier 2	
☐ Alzheimer's Disease	• Progressive screenings using the mini-mental state examination (MMSE) test, Mini-Cog test or the Montreal Cognitive Assessment (MoCA).
☐ Diabetes (insulin-dependent	• Clinical and Laboratory diagnosis
☐ Parkinson's Disease	• Proof of appropriate neurological testing
☐ Loss of Independent Living	• Inability to perform 2 or more activities of daily living
Tier 3	
☐ Invasive Cancer	• Pathological Diagnosis
☐ End Stage Renal Failure	• Medical records from the nephrologist • Proof of renal dialysis
☐ Loss of Sight	• Medical records from ophthalmologist; including refractions, visual acuity, and visual field • Proof must document that the blindness was due to Accidental Injury or Sickness; and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis.
☐ Loss of Speech	• Medical records from a speech pathologist • Clinically-proven that the loss of ability to speak has continued without interruption for a period of at least six (6) consecutive months
☐ Loss of Hearing	• Medical records from an audiologist • Proof of irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months after diagnosis
☐ Coma	• Medical records from neurologist • Proof of complete and continuous unconsciousness state not less than 24-96 hours induration which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes
☐ Severe Burns	• Medical records from plastic surgeon • Proof that covered person has sustained third degree burns covering at least 20% of the surface area of their body

Tiers 1, 2 & 3/Child Major Condition Form – Attending (Treating) Physician Statement

Tier 3 continued	
☐ Permanent Paralysis due to Accident	• Medical records • Proof that loss is expected to be permanent; been present continuously for at least 180 days; caused by injury sustained in an accident; evidenced by the total and irreversible loss of use of two or more limbs; marked by loss of muscle function in two arms, two legs, or one arm and one leg
☐ Occupational HIV	• Medical records • Proof that the cause of HIV must be from an Accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the 12 months preceding diagnosis; accident occurred while covered person was following the normal occupational duties and reported in accordance with the established occupational procedure for such accidents; the covered person must have undergone a blood test within 5 days of the accident which indicate the absence of HIB or antibodies to such a virus; within 12 months of the accident, the covered person must undergo a follow up blood test indicating the presence of HIV or antibodies to such a virus
☐ Major Organ Transplant	• Medical records, demonstrating major organ failure • Proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or • its successor for a human to human replacement of the failing organ
☐ Stroke	• Documented neurological impairment or deficits; • Evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test); • Permanent neurological deficit measured three months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and • Which was made after the Effective Date of Insurance
☐ Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease);	• Proof of appropriate neurological testing
☐ Multiple Sclerosis	• Diagnosis is typically based on observation of symptoms over a period of time and findings on MRI.
☐ Heart Attack	• Displays new EKG changes consistent with and supporting the diagnosis of Heart Attack; • Exhibits elevation of cardiac enzymes above generally accepted laboratory levels of normal (in case of CPK, a • CPK-MB measurement must be used); • Is confirmed by imaging studies such as thallium scans, MUGA scans or stress echocardiograms; and • Occurs after the Effective Date of Insurance.
CHILD MAJOR CONDITION	
☐ Downs Syndrome	• Proof of appropriate genetic testing
☐ Juvenile Diabetes (Type 1)	• Clinical and Laboratory diagnosis
☐ Cerebral Palsy	• Proof of appropriate neurological testing
☐ Cleft Palate	• Clinical Diagnosis
☐ Cystic Fibrosis	• Proof of appropriate genetic testing
☐ Spina Bifida	• Proof of appropriate neurological testing, physical exam or imaging

Tiers 1, 2 & 3/Child Major Condition Form – Attending (Treating) Physician Statement

Treatment Information

Diagnosis (including any complications)_____ ICD-9/ICD-10 Code_____

Date the symptoms first appeared:____/____/____ Date of the first visit:____/____/____

Date of the 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, please provide the referring physician information:

Referring Physician Name_____ Phone No. (____)_____

Referring Physician Address_____

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

Printed Name of Physician_____ Phone No. (____)_____

Street Address_____ Specialty _____

City_____ State_____ ZIP Code _____

Signature of Attending Physician_____ Date____/____/____