INSTRUCTIONS FOR FILING A CLAIM

Supplemental Benefits

Please review the information below to determine what is required for us to process your claim. All claim packet forms, except the Attending Physician's Statement (if required by policy), should be completed by the patient. If the patient is a minor then the policy holder is responsible for completing the forms.

CLAIM PACKET FORMS

1. **Fraud Warnings:** Read the fraud warning based on the state the policy was issued. The fraud warning applies to all claim forms and related documents that are submitted for claims processing.
2. **Claim Form:** Fill out the form completely to include a signature and sign date. Missing information may delay the claim process.
3. **HIPAA Authorization Form for Disclosures of a Claimant's Protected Health Information:** Read, sign, and date the authorization to disclose health information as outlined within the form. This form will authorize us to obtain the necessary information to process your claim.
4. **HIPAA Authorization Form for Disclosures of an Insured's Protected Health Information to Designated Personal Representative(s):** If the patient would like to authorize an individual to call/discuss sensitive policy or claim information with our office, then the form should be completed. The patient may also provide a copy of a current General Durable Power of Attorney in lieu of this form.
5. **Attending Physician's Statement:** Provide the Attending Physician's Statement to the primary treating physician to complete (***not required for cancer screening claims, transportation claims, or hospital surgical claims***).

REQUIRED DOCUMENTS FOR CLAIMS PROCESSING *(Review your policy to determine what may be required)*

Your policy may require that you include fully itemized bills or operative reports for surgeries; or itemized outpatient/inpatient hospital/facility/physician bills, which could include UB-04 standard billing forms from the hospital. The bills should include the patient's name and dates of service (**Note: Cigna will not request bills; bills will need to be submitted by the insured*).

Once a claim is established then bills may be submitted for reimbursement as the service is incurred.

We may request medical records from physician(s) who treated the patient prior to and/or after the policy effective date. In the event that you provide medical records to us directly, it may be necessary for us to verify and/or obtain additional information from your health care professional. *Note: To help aid in our fraud prevention efforts, please understand that all medical records are requested through a third party vendor experienced in obtaining medical records and are upheld to all HIPAA (Health Insurance Portability and Accountability Act) standards; medical records will only be accepted through this vendor and intervention by any other party is not necessary.*

Your policy may require proof of other insurance payments, discounts, or adjustments. Please review your policy. We ask that you submit other insurance Explanation of Benefits or documentation showing any discounts/adjustments. If you do not have other insurance or Medicaid, please indicate this when submitting claims.

Please do not hesitate to contact us by phone or email with any questions you may have. You will find our contact information below along with how to send us your claim.

Sincerely,

Life & Health Claims Department

QUESTIONS?

Call and speak to a Customer Service Advocate or send an email to the Life & Health Claims Department.

- **CALL:** Customer Service Department at 1-866-459-1755 (Monday – Friday | 8 AM to 5 PM CST), or
- **EMAIL:** Life & Health Claims Department at CSBHealthClaims@cigna.com (Please do not email claims)

FILE A CLAIM:

You may submit claims by fax or mail. Please remember to reference your policy number on claim documents.

- **FAX TO:** 1-877-826-6237, or
- **MAIL TO:** Cigna Supplemental Benefits | PO Box 26580 | Austin, Texas 78755-0580

Life & Health Claims

AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean Cigna, Great American Life Insurance Company®; Loyal American Life Insurance Company; or American Retirement Life Insurance Company; or Central Reserve Life Insurance Company; or Continental General Insurance Company; or Provident American Life & Health Insurance Company; or United Teacher Associates Insurance Company..

2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically related facility, the U.S. Veterans Administration and Selective Service System, insurance company, the Medical Information Bureau, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's claims and underwriting representatives, by and through the Company's contracted agent, any such records or information.

3. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.

4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 26580, Austin, Texas 78755-0580.

5. This authorization will expire twenty-four (24) months from the date the authorization is signed.

6. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitlement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment of benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization

7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.

8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.

9. I understand that I, or my personal representative, am entitled to receive a copy of this authorization upon request.

If you are the representative of the claimant, describe the scope of your authority to act on the claimant's behalf: _____

_____ Claimant Name

_____ Name of claimant's personal representative, if applicable

_____ Signature of claimant (or claimant's representative)

_____ Relationship of personal representative to the claimant

_____ Date of signature

_____ Policy / contract number

Life & Health Claims

AUTHORIZATION FORM
FOR DISCLOSURES OF AN INSURED'S PROTECTED HEALTH INFORMATION
TO DESIGNATED PERSONAL REPRESENTATIVE(S)

I hereby authorize the use or disclosure of protected health information about me by the Company as described below. As used in this authorization the Company shall mean Cigna, Great American Life Insurance Company®; Loyal American Life Insurance Company; or American Retirement Life Insurance Company; or Central Reserve Life Insurance Company; or Continental General Insurance Company; or Provident American Life & Health Insurance Company; or United Teacher Associates Insurance Company. The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

_____
name relationship address

_____
name relationship address

_____
name relationship address

Describe fully the protected health information that is allowed to be disclosed to the above named personal representative(s).

_____

_____

I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of the Company, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Officer at P.O. Box 26580, Austin, TX 78755-0580.

This authorization will expire upon the earliest of the following date:_____; or twenty-four (24) months from the date the authorization is signed.

I understand that I am not required to sign this authorization form and that the Company will not condition the provision of payment to me on the signing of this authorization. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I or my personal representative am entitled to receive a copy of this authorization upon request.

_____
Insured Name

_____
Name of personal representative, if applicable / Relationship of personal representative to Insured

_____
Signature of Insured (or Insured's representative) / date signed

FRAUD WARNINGS FOR FILING A CLAIM

Read the fraud warning according to the state the policy was issued.

The following fraud warning applies to AK, AZ, CA, CT, DE, GA, HI, IA, ID, IL, IN, KS, LA, MA, MI, MN, MO, MS, MT, NC, ND, NE, NH, NV, SC, SD, TX, UT, VT, WI, WY: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

STATE	STATE SPECIFIC FRAUD WARNINGS
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.
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.
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	"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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."
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.
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.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy 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.
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	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.
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."
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.

Claim Form

Read the enclosed instructions and include the required documents with your claim.

METHODS TO SUBMIT THE CLAIM:

- o Fax to 1-877-826-6237, or
- o Mail to PO Box 26580 / Austin, Texas 78755-0580

QUESTIONS?

- o Call Customer Service at 1-866-459-1755 (Monday - Friday 8 AM to 5 PM CST), or
- o Email Questions to the Life & Health Claims Department at CSBHealthClaims@cigna.com

Cigna

Supplemental Benefits

PATIENT / POLICYHOLDER INFORMATION

1. Policyholder Name (first, middle, last)	2. Policy / Contract Number	3. Claim is For: ☐ Child ☐ Self ☐ Spouse	4. Daytime Telephone Number
5. Patient's Name (first, middle, last)	6. Patient's Date of Birth	7. Patient's Gender ☐ Female ☐ Male	8. Patient's Social Security Number
9a. Address Change? ☐ Check for Yes (attach documentation) 9b. Name Change? ☐ Check for Yes (attach documentation)	10. Patient's Address (street, city, state, and zip code)		11. Does the Patient Have Medicaid? ☐ No ☐ Yes a. If Yes, Provide the Medicaid # Below: #:

Filing Claim For:

12. Select Option

- ☐ Accident
- ☐ Angioplasty
- ☐ Aortic Surgery
- ☐ Blindness
- ☐ Cancer
- ☐ Cancer Screening
- ☐ Carcinoma in Situ
- ☐ Coma
- ☐ Coronary Artery Bypass Surgery
- ☐ Dread Disease
- ☐ End Stage Renal Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Heart Valve Replacement/Repair Surgery
- ☐ Hospital Confinement
- ☐ ICU
- ☐ Major Organ Transplant (heart)
- ☐ Major Organ Transplant (other than heart)
- ☐ Paralysis (not from stroke)
- ☐ Stroke
- ☐ Severe Burns
- ☐ Other (specify below): _____

13. Date of Diagnosis/Accident	14. Date Symptoms First Appeared

IF ACCIDENT RELATED, COMPLETE # 15-17

15. Investigated by Law Enforcement? ☐ No ☐ Yes (If yes, attach a police report with this form)	16. How did the Accident Happen?	17. If Employment Related - Worker's Comp: a. Claim#_____ b. Date Filed _____

PATIENT'S HEALTH CARE PROFESSIONAL INFORMATION

18. List ALL Doctors and Hospitals the Patient Received Treatment From for the Past 5 Years. Attach a Separate Page if Needed.

Doctor's Full Name / Hospital	Address (street, city, state, and zip code)	Specialty	Date 1st Seen	Phone Number

CERTIFICATION

The furnishing of these forms, or acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

X _____ _____

Patient Signature (or policy owner if the patient is a minor) **Date of Signature**

Administering Medicare Supplement and Supplemental Health business for:
Continental General Insurance Company, Great American Life Insurance Company and United Teacher Associates Insurance Company

ATTENDING PHYSICIAN'S STATEMENT

TO BE FULLY COMPLETED BY THE PRIMARY ATTENDING PHYSICIAN

METHODS TO SUBMIT THE FORM:

- o Fax to 1-877-826-6237, or
- o Mail to PO Box 26580 / Austin, Texas 78755-0580

QUESTIONS?

- o Call Customer Service at 1-866-459-1755 (Monday - Friday 8 AM to 5 PM CST), or
- o Email Questions to the Life & Health Claims Department at CSBHealthClaims@cigna.com

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Supplemental Benefits

PATIENT / POLICYHOLDER INFORMATION

1. PATIENT'S NAME (First, Middle, Last)	2. PATIENT'S DATE OF BIRTH	3. PATIENT'S GENDER	4. PATIENT'S SOCIAL SECURITY #
		☐ Female ☐ Male	

5. PATIENT'S ADDRESS

Street

City / State Zip Code

6. POLICYHOLDER'S NAME (first, middle initial, last name)

7. POLICY / CONTRACT NUMBER

DIAGNOSIS / PATIENT SYMPTOM INFORMATION

8. LIST THE DIAGNOSIS OR DESCRIPTION OF ILLNESS / INJURY

1

2

3

4

5

9. DATE OF DIAGNOSIS:	10. DATE FIRST CONSULTED FOR CONDITION	11. DATE SYMPTOMS FIRST APPEARED	12. DATE LAST TREATED

13A. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ No ☐ Yes

13B. IF YES, PROVIDE DETAILS INCLUDING DATES OF TREATMENT AND DIAGNOSIS

14A. IS CONDITION DUE TO AN ACCIDENT ? ☐ No ☐ Yes

14B. IF YES, HOW DID THE ACCIDENT HAPPEN?

PRIOR TREATMENT / REFERRAL / HOSPITAL CONFINEMENT / FACILITY INFORMATION

15A. WAS PATIENT TREATED BY ANOTHER PHYSICIAN PRIOR TO YOUR TREATMENT? ☐ No ☐ Yes

15B. IF YES, PROVIDE NAME & ADDRESS OF ALL PHYSICIANS KNOWN (ATTACH A SEPARATE PAGE IF NEEDED)

Physician Name & Address (street, city, state, and zip code)

Physician Name & Address (street, city, state, and zip code)

Physician Name & Address (street, city, state, and zip code)

Physician Name & Address (street, city, state, and zip code)

16. PROVIDE THE FOLLOWING INFORMATION IF YOU REFERRED THE PATIENT TO ANOTHER PHYSICIAN:

NAME:

ADDRESS:

Street

City, State, and Zip Code

PHONE #:

REFERRAL DATE:

17A. WAS PATIENT CONFINED TO A HOSPITAL OR INTENSIVE CARE UNIT (ICU)? ☐ Inpatient ☐ Intensive Care Unit (ICU) ☐ No

17B. ADMISSION DATE, IF YES:

17C. DISCHARGE DATE, IF YES:

18. FOR HOSPITALIZATION SERVICES, PROVIDE THE FACILITY INFORMATION

FACILITY NAME:

ADDRESS:

Street

City, State, and Zip Code

PHONE NUMBER:

ATTENDING PHYSICIAN INFORMATION

Attending Physician Printed Name

X

Attending Physician Signature Date

Address (street, city, state, and zip code)

Tax ID (or SSN) Phone Number(s)

TRANSPORTATION CLAIM FORM

Read the instructions below and include the required documents with your claim.

METHODS TO SUBMIT THE CLAIM:

o Fax to 1-877-826-6237, or
o Mail to PO Box 26580 / Austin, Texas 78755-0580

QUESTIONS?

o Call Customer Service at 1-866-459-1755 (Monday - Friday, 8 AM to 5 PM CST), or
o Email Questions to the Life & Health Claims Department at CSBHealthClaims@cigna.com

Supplemental Benefits

INSTRUCTIONS:

The patient should complete fields 1-14 then provide the form to the treating physician to complete fields 15-20. Return the completed / signed form with proof of treatment, such as a bill or copay receipt. If you are filing a claim for multiple dates of transportation then submit bills / receipts for each date of service that includes a description of the treatment.

PATIENT / POLICYHOLDER INFORMATION

1. Policyholder Name (first, middle, last)	2. Policy / Contract Number	3. Claim is For: ☐ Child ☐ Self ☐ Spouse	4. Daytime Telephone Number
5. Patient's Name (first, middle, last)	6. Patient's Date of Birth	7. Patient's Gender ☐ Female ☐ Male	8. Patient's Social Security Number
9. Patient's Marital Status ☐ Divorced ☐ Married ☐ Single ☐ Widowed	10. Patient's Address (street, city, state, and zip code)		11a. Address Change? ☐ Check for Yes (attach documentation) 11b. Name Change? ☐ Check for Yes (attach documentation)

TRANSPORTATION / LODGING BENEFIT INFORMATION

12. Type of Transportation:
☐ Airline* ☐ Bus* ☐ Personal Vehicle ☐ Railroad*

***For airline, bus, and/or railroad, attach a copy of the transportation receipt with this claim form (required for claims processing).**

13. Filing for Lodging Expenses? ☐ No ☐ Yes (If yes, attach lodging expense/charge with this claim form; required document)

MILEAGE INFORMATION

14. List the transportation date(s), health care professional providing treatment information, and mileage. Attach a separate page if needed.

Date(s)	Name of Health Care Professional	Address of Health Care Professional (street, city, state, and zip code)	Mileage		
			To Location	From Location	Total Mileage

PATIENT CERTIFICATION

The furnishing of these forms, or acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

X _____ _____

Patient Signature **Date of Signature**

HEALTH CARE PROFESSIONAL VERIFICATION (TO BE COMPLETED BY THE PHYSICIAN)

15. Name of Office/Facility	16. Address of Office / Facility	17. Telephone Number(s)
18. Type of Treatment Provided to the Patient	19. Was Treatment Available Where the Patient Lives? ☐ No ☐ Yes	20. If "No," List Nearest Hospital for Treatment

PHYSICIAN CERTIFICATION (TO BE COMPLETED BY THE PHYSICIAN)

The undersigned certifies that information regarding the patient is correct according to the office / facility records on file.

X _____ _____ _____

Physician's Signature **Full Name of Physician (printed)** **Date of Signature**