Fax to: Claims 1.800.880.9325

From:________________________
Fax Number:__________________
Date:_________________________
Number of pages:______________

Claim Form and Instructions

Your disability or critical illness claim must be filed within 12 months of your date of loss.

What can I do to avoid delays?

Missing information will delay the processing of your claim. Please be sure you:

- ❑ **Sign** and return the attached Certification on page 3 and Authorization on page 7.
- ❑ **Complete** the sections that apply to your specific claim. Please have your **doctor and employer** complete their sections, if applicable.
- ❑ **Enclose** copies of all **bills** connected with your claim, if applicable.

When should I expect a reply?

- If you are filing a claim for a sickness or health condition occurring within the first 6 to 24 months of your policy/certificate (based on policy requirements), we need to determine if the condition is **pre-existing**. We may have to write for this information which may delay your claim. **Please include the signed authorization with your claim and ask your doctor to promptly respond to our request for medical information.**

We will call you to advise when your claim information is in processing. Mail time is a large contributor to the time it takes for our response to reach you. **Mail** may take up to four or five days each way.

To avoid mail delays:

- **Fax** your claim to us at **1.800.880.9325**. If you are faxing your claim, please make a copy of the back pages and fax all pages of the claim together. **Please do <u>not</u> mail the original document but keep it for your records.** Please allow **at least two business days** for our automated service center to be updated with information confirming receipt of your fax. You will receive an automated call when your fax has been updated in our system.
- Have your payment returned by **overnight delivery** by initialing the Service Release below. A $18.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. **We will only overnight payments of $100.00 or more. *<u>A street address is required.</u> Your check will be delivered Monday through Friday; however, the time is not guaranteed.***

OPTIONAL SERVICE RELEASE AGREEMENT – Please initial below as indicated.

I authorize The Paul Revere Life Insurance Company to facilitate processing this claim by releasing its details if he/she is inquiring on my behalf.

_____ local sales representative (initial) _____ plan administrator (initial) ______ spouse, family member or significant other (initial)

______ (initial) I authorize The Paul Revere Life Insurance Company to communicate information on the status of this claim through **electronic messaging** at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/answering machine. I will program phone number 1.800.325.4368 into my phone to avoid calls being blocked.

______ (initial) Yes, please deduct the $18.00 fee (cost subject to rate increases) to **overnight** any applicable benefits from my claim payment for this claim. This fee does not include weekend delivery. I understand this fee will be deducted for **future payments** for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under $100.00 will be sent by regular mail.

Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying The Paul Revere Life Insurance Company in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by The Paul Revere Life Insurance Company.

- Benefits are payable to you unless we receive a written authorization from your provider to assign benefits to them. This is called an **assignment.** If you wish to assign your benefits, please attach a signed written request.
- If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.

CLAIMANT NAME:X________________________________**SOCIAL SECURITY NUMBER:**______________

Mail to: **The Paul Revere Life Insurance Company**
Processing Center
PO Box 100195
Columbia SC 29202-3195

Fax to: 1.800.880.9325
If you fax your claim, there is no need to mail the original. Reminder: Please copy the back pages and fax all the pages of the claim together.

WELLNESS/HEALTH SCREENING

If you wish to file a **Wellness/Cancer Screening claim for a test performed within the past 12 months**, you'll need to submit the type and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number. **You may:**

- **FILE BY PHONE!** Call **1.800.325.4368** and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week, **or**
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "**Wellness Test**."

FAX this to us at **1.800.880.9325** ***or*** **MAIL** to P.O. Box 100195, Columbia SC 29202.
If your Wellness/Cancer Screening test was more than one year ago, you must fax or mail us a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.

Please note: If your cancer policy includes a second part to the screening benefit, bills for tests covered and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

CANCER

Please complete the sections that apply to your coverage.

- For Internal Cancer – **Attach** a copy of the **pathology report** from your initial diagnosis.
- Attach copies of itemized statements for all medical expenses incurred relating to the diagnosis and treatment of your malignancy. Please clearly write your name and social security number on each bill.
- For Skin Cancer – Attach a copy of your pathology report for each date of service a lesion was biopsied and/or removed.
- Transportation and Lodging – Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.
- ***If you are claiming disability, please have your employer and doctor provide any applicable information under SECTIONS D & E.***

If you have any questions while completing this claim form, please call us at 1.800.325.4368. We will assist you with the information and forms needed to successfully complete this process.

Your claim must be filed within 12 months of your date of loss.
Please **check** the type of claim you are filing below:

- ❑ **Wellness** - See top of page 2
- ❑ **Cancer** - See Botom of page 2.
- ❑ **Routine Pregnancy** - See page 4 if you are filing for benefits for normal post-delivery disability. Pages 5 and 6 are not necessary.
- ❑ **Total Disability** - (Accident/Sickness/Pregnancy complications) Sections D & E contain parts for both your employer and doctor to complete. See pages 5 and 6.
- ❑ **Accidental Injury** - Section A, page 4, requests specific information from you about the circumstances of your injury.
- ❑ **Hospital Confinement, Intensive Care, Outpatient Surgery and/or Rehabilitation Unit** - Have your doctor complete Section C, page 5, and send copies of your hospital, outpatient surgery, and/or Rehabilitation Unit bills.

This claim is for: ❑ Self ❑ Spouse ❑ Dependent: if over 18, name of school____________________

Name of Claimant____________________ Name of Policyowner (if not claimant) ____________________

Social Security Number: ____________________ **Social Security Number:** ____________________

Date of Birth (mm/dd/yyyy): ____/____/______ ❑ Male ❑ Female Date of Birth (mm/dd/yyyy): ____/____/______ ❑ Male ❑ Female

Policy Number: ____________________

Mailing Address ____
Street (Apt. #) City State Zip

(must include street address for overnight delivery)

Has your address changed since we last heard from you? ❑ **YES** ❑ **NO**
Has your name changed since we last heard from you? ❑ **YES** ❑ **NO If yes, attach copy of marriage certificate, drivers license or other legal documentation.**

Home Phone Number: (______) ____________________ Work Phone Number: (______) ____________________

Fax Number: (______) __________________ Policyowner email Address:____________________________

If you are claiming disability, please list the dates you were unable to work: from ____/_____/______ to ____/_____/______

***Please print* INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL**
Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).

1.____________________________
Full name of treating doctor
____
Mailing Address
____
City State Zip Code
(____)______________ (____)______________
Phone number Fax number

2.____________________________
Full name of referring doctor/hospital
____
Mailing Address
____
City State Zip Code
(____)______________ (____)______________
Phone number Fax number

3.____________________________
Full name of primary doctor
____
Mailing Address
____
City State Zip Code
(____)______________ (____)______________
Phone number Fax number

4.____________________________
Other
____
Mailing Address
____
City State Zip Code
(____)______________ (____)______________
Phone number Fax number

CERTIFICATION

Policyholder/Employee's Name________________________ **Social Security #**________________

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the "Claim Fraud Warning and State Versions" form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form. 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.

PLEASE ALSO SIGN AND DATE THE AUTHORIZATION ON PAGE 7.

X______/______/_________ **X**________________________ **X**________________________
Date (mm/dd/yyyy) PATIENT SIGNATURE POLICYOWNER/EMPLOYEE SIGNATURE

CLAIMANT NAME:X______________________________ **SOCIAL SECURITY NUMBER:**_______________

A. ACCIDENTAL INJURY- please **complete** and **attach itemized copies** of any related **bills** including **doctor**, **ambulance, emergency room**, **hospital, and/or rehabilitation unit**. Bills should include **diagnosis** information from your medical provider.

Date of accident (mm/dd/yyyy): ____/_____/_____ **Time of accident:** __________________ am / pm (circle one)

Tell us how your accident happened:

____

____

____

____

____

Were you at work, working for wage or profit, at the time of your accident? ❏ yes ❏ no

Have you ever had a similar injury? _________If so, please tell us when (mm/dd/yyyy): _________________________

If you are claiming disability, please have your employer and doctor provide any applicable information under SECTIONS D & E.

To be completed and signed by your doctor

B. ROUTINE PREGNANCY (6 weeks for vaginal delivery or 8 weeks for c-section, less the elimination period)

If disabled due to complications of pregnancy, before or after delivery, complete *Section E on page 6.*

Date of Delivery (mm/dd/yyyy):_____/______/______ **Type delivery:** Vaginal / C-Section (circle one)

Date you first treated patient for this pregnancy (mm/dd/yyyy):______/_______/________

List other treatment dates for this pregnancy ____/____/____ , ____/____/____, ____/____/____ , ____/____/____

____/____/____ , ____/____/____, ____/____/____ , ____/____/____

Dates of Hospital Confinement (mm/dd/yyyy): ____/____/____ - ____/____/____

Name of Hospital: ______________________________ Hospital Phone Number: (_____) _______________________

Name of doctor: _______________________________ Phone Number: (_____)___________ Fax: (_____)_____________

Address: ____

Email address:______________________________________**Tax ID or SSN:** _______________________

Do you have an authorization on file to release information to Paul Revere ❏ yes ❏ no

Treating Doctor's Signature: _______________________________ Date (mm/dd/yyyy): __________________________

Referring Physician: _________________________________ Phone Number: (_____) _________________

Mailing address ____

Employer information on next page

CLAIMANT NAME: X________________________________ SOCIAL SECURITY NUMBER:________________

C. HOSPITAL CONFINEMENT, INTENSIVE CARE, SURGERY, AND/OR REHABILITATION UNIT BENEFIT(S).

Please send an itemized copy of your hospital and/or rehabilitation bill(s), which includes the diagnosis, admission and discharge dates. Have your doctor complete this section if your bills do not include diagnosis information. Please send a copy of the anesthesiology bill if outpatient surgery was performed.

INTENSIVE CARE / HOSPITAL CONFINEMENT / REHABILITATION UNIT

Place of Confinement	Dates of Service From (mm/dd/yyyy)	To (mm/dd/yyyy)
Intensive Care including Coronary Care Unit		
Hospital (Private, Semi-Private, Other)		
Rehabilitation Unit		

Diagnosis/ICD-9 Code(s): ________________________________

Hospital: ________________________________ Phone Number (____)________________

Hospital Address: ________________________________

Rehabilitation Unit Address: ________________________________ Phone Number (____)________________

Date(s) of office visit(s) following confinement: (mm/dd/yyyy): ____/____/____- ____/____/____

SURGERY

Type of Surgery	Date(s) of Service From (mm/dd/yyyy)	To (mm/dd/yyyy)	Procedure Description/Procedure Code
Inpatient			
Outpatient			

Diagnosis/ICD-9 Code(s): ________________________________

Date(s) of office visit(s) following outpatient surgery (mm/dd/yyyy): ____/____/____ - ____/____/_____

Hospital: ________________________________ Phone Number: (____) ________________

Hospital Address: ________________________________

DOCTOR'S INFORMATION:

Signature of doctor: X ________________________________ Date (mm/dd/yyyy): ____/____/____

Name of doctor: ________________________ Phone Number: (____)____________ Fax: (_____) _________

Address: ________________________________

Email address:________________________________Tax ID or SSN: ________________

If you are claiming disability, please have your employer complete the section below and have your doctor complete SECTION E.

D. To be completed and signed by your *EMPLOYER:*

Name of Employer: ________________________________

Email address:________________________________

Employee working at any other place of employment?
❑ yes ❑ no If yes, where ____________________

Dates this employee has been unable to work:

From: ____/____/____ am/pm To: ____/____/____ am/pm

From: ____/____/____ am/pm To: ____/____/____ am/pm

Date employee returned to main or principal duties:

____/____/____ ❑ Part time _____ Number of hours/week
❑ Full time

Date employee returned to light duty: ____/____/____

Monthly salary $__________ Hourly salary $ __________

Did the accident occur while working for wage/profit?

❑ yes ❑ no If yes, list date of injury: ____/____/____

Phone Number: (____)____________________

Fax Number: (____) ____________________

Employee's Job Title ____________________

Employee's job duties include:

Lifting ❑ less than 15 lbs. ❑ 15 to 44 lbs. ❑ over 45 lbs.

Stooping/bending	❑ none	❑ seldom	❑ frequent
Crawling/climbing/ kneeling	❑ none	❑ seldom	❑ frequent
Reaching/pulling/ pushing	❑ none	❑ seldom	❑ frequent
Repetitive	❑ none	❑ seldom	❑ frequent
Management duties	❑ none	❑ seldom	❑ frequent

Sitting (Number of hours each day): ____________

Standing/Walking (hours each day): ____________

Has Workers' Compensation been approved? ❑ yes ❑ no

Name and address of Workers' Compensation carrier: ________________________________

____

Is modified or light duty available? ❑ yes ❑ no If yes, date available. ________________________________

Signed: X ________________________ **Title:** ______________ **Date (mm/dd/yyyy):** ____/____/____

(To be signed by your employer)

CLAIMANT NAME: X ________________________________ **SOCIAL SECURITY NUMBER:** ________________

E. DISABILITY BENEFITS. To be completed and signed by the DOCTOR treating you for this disability:

Diagnosis/ primary disabling condition/ ICD9 Code(s): ____

Secondary conditions contributing to this disability: ____

Would the patient be disabled without regards to these secondary conditions? ❑ yes ❑ no

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment: ____

Is this condition the result of an accidental injury? ❑ yes ❑ no If yes, please provide us with the date and description.

____

Dates of Inpatient Hospital Confinement: From: ____/____/_____ To: ____/____/_____

Hospital: ____
Name Address

List any surgeries performed and submit a copy of the operative report. ________________________________

Is this patient permanently disabled? ❑ yes ❑ no If yes, what are the permanent restrictions/limitations? ________

____

How soon do you expect significant improvement in the patient's medical condition? ______ # weeks/months (circle one)

Dates unable to work: Full Duty: From: _______/________/____________ To: _______/________/____________

Dates unable to work: Partial Duty: From: _______/________/____________ To: _______/________/____________

List Restrictions/Limitations preventing work ____

Is this patient considered to be unable to perform 2 or more activities of daily living?
Yes / No (circle one) If yes, which ADLs cannot be performed? *(dressing, eating, transferring, toileting, and meal preparation)* ____

____

For what period? From ____/____/_____ To ____/____/____
(This information will be used in accordance with state regulations and policy provisions.)

Anticipated return to work/release date: ___________________________________ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

If due to complications of pregnancy prior to delivery, what is EDC? _____/_____/_______

Dates of office visits **(mm/dd/yyyy):** ____

Recommended frequency of treatment: ____

Signature of doctor: _____________________ **Date (mm/dd/yyyy):** ____/____/_____ **Patient Account #:** ___________

Name of doctor: ___________________________ Phone Number: (_____)_____________ Fax: (______)___________

Specialty: ____

Address: ____

Email address: ____ **Tax ID or SSN:** _____________________

____

Full name of referring doctor

____

Mailing Address City State Zip Code

(_________)______________________________________ (_________)___________________________________

Phone number Fax number

NOTE: Please make a copy of the patient's signed authorization to release information for your records. If your facility requires a special authorization, please have your patient sign the form and include it with this claim.

Phone 1.800.325.4368 *Fax 1.800.880.9325*

Authorization for The Paul Revere Life Insurance Company

For the purpose of evaluating my eligibility for insurance and eligibility for benefits under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to The Paul Revere Life Insurance Company (Paul Revere) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Paul Revere to evaluate my application or claim forms may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Paul Revere obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Paul Revere will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier and a copy is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Paul Revere has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If revoked, Paul Revere may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: The Paul Revere Life Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Paul Revere may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

____________________	____________________	____________________	__________
(Printed name of individual subject to this disclosure)	(Social Security Number)	(Signature)	(Date Signed)

If applicable, I signed on behalf of the insured as ____________________________(indicate relationship). If legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

____________________	____________________	__________
(Printed name of legal representative)	(Signature of legal representative)	(Date Signed)