

# Helpful Hints

*From the Claims Department to guide you through filing your Accident claim*

We value you as a customer and want to make the process of filing a claim as fast and as simple for you as possible. To assist you with the process, we're providing these helpful hints:

## SUBMITTING A CLAIM

When submitting a claim, attention to the following details will assure that your claim moves quickly and benefits due are processed without delay.

- Submit a fully completed and signed claim form.
- Be sure to include the provider's name, address and phone number with all claims.
- Provide the first diagnosis date for the health condition for which bills are being submitted.
- Itemized bills are required that include dates of service, procedure codes and diagnosis codes before benefits can be considered (e.g. CMS 1500, UB04, etc.)
- For Puerto Rico Resident only: When submitting an Emergency Room claim, please include a copy of your Explanation of Benefits from your primary insurance carrier, if applicable.

### TOP 3 REASONS CLAIMS MAY BE DELAYED

1. *Itemized bills* are not sent with the claim form.
2. *Supporting documents* such as the accident report, death certificate or any other information surrounding the accident are not sent with the claim form.
3. A thorough *description of the accident* and the *date* it occurred are not sent with the claim.

## WHERE TO SUBMIT CLAIMS

Mail all accident claims to:

Claim Processing  
P.O. Box 2024  
Carmel, IN 46082-2024

Express packages should be addressed to:

Attn: Claim Processing 2024  
11825 N. Pennsylvania Street  
Carmel, IN 46032

Faxes for the health claims should be sent to  
(317) 208-8656.

Phone calls may be directed to customer service at  
(800) 541-2254.



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# ACCIDENTAL INJURY CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.

Willcac Life Insurance Company  
P.O. Box 2024  
Carmel, IN 46082-2024  
(800) 541-2254

POLICY OR CERTIFICATE NUMBER: \_\_\_\_\_

## SECTION A: OWNER INFORMATION (Please print)

|   |                            |                            |
|---|----------------------------|----------------------------|
| LAST NAME   | FIRST NAME                 | MIDDLE INITIAL             |
| SOCIAL SECURITY NUMBER  | BIRTH DATE<br>__/__/__     | PHONE NUMBER (HOME)<br>( ) |
| ADDRESS <input type="checkbox"/> Check box if this is a new permanent address |                            |                            |
| CITY  | STATE                      | ZIP                        |
| IF MAILING ADDRESS IS A PO BOX, PLEASE INDICATE PHYSICAL ADDRESS HERE:        |                            |                            |
| PLACE OF EMPLOYMENT   | PHONE NUMBER (WORK)<br>( ) |                            |
| ADDRESS   |                            |                            |
| CITY  | STATE                      | ZIP                        |

## PATIENT INFORMATION (If different than owner; Please print)

|   |   |   |
|---|---|---|
| LAST NAME   | FIRST NAME  | MIDDLE INITIAL  |
| SOCIAL SECURITY NUMBER  | BIRTH DATE  | PHONE NUMBER<br>( )   |
| IF MAILING ADDRESS IS A PO BOX, PLEASE INDICATE PHYSICAL ADDRESS HERE:  |   |   |
| <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE  | <input type="checkbox"/> SINGLE<br><input type="checkbox"/> MARRIED<br><input type="checkbox"/> OTHER | RELATIONSHIP:<br><input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT<br><input type="checkbox"/> CHECK IF DEPENDENT IS FULL-TIME STUDENT<br><input type="checkbox"/> CHECK IF INSURED IS DECEASED - DATE DECEASED __/__/____ |
| Where did this accident occur? <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OTHER _____                   |   |   |
| What was the date you first consulted a physician because of this accident? __/__/__  |   |   |
| PLACE OF EMPLOYMENT   | PHONE NUMBER (WORK)<br>( )  |   |
| Please provide the names, addresses and phone numbers of any physician who has treated you or with whom you have consulted in the last two years: |   |   |
| Please describe where and how this accident occurred; please also include the date/dates of the accident:   |   |   |
| PR residents only: Please provide the following information for your Major Medical Insurer:   |   |   |
| NAME OF COMPANY   | PRIMARY INSURER NAME  |   |
| STREET ADDRESS  | CITY  | STATE   |
| GROUP NUMBER  | PHONE NUMBER  | ZIP   |

Please be sure to include the following information along with this claim form:

- ☐ Itemized bills from facility including diagnosis and/or procedure codes and charge amounts  
(Itemized bills may include but are not limited to the following claim forms: UB04, CMS 1500, etc.)
- ☐ All supporting documentation from the accident (accident report, death certificate, etc)

By signing my name on this document, I declare that all of the information given is true and correct to the best of my knowledge and belief. I acknowledge I have received all required fraud warnings at the time of executing this form.

PATIENT'S SIGNATURE (or legal representative)

RELATIONSHIP

DATE

OWNER'S SIGNATURE (or legal representative)

DATE



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## FRAUD WARNING NOTICES

### PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**NOTICE:** Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

**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, DELAWARE, FLORIDA, IDAHO, NEW YORK:** Your state requires us to notify you that: any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony as further defined by your state statute.

**ARKANSAS, HAWAII, LOUISIANA, MAINE, NEW MEXICO, RHODE ISLAND, TENNESSEE, TEXAS, VIRGINIA, 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.

**ARIZONA, KENTUCKY, OHIO:** WARNING: 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.

**CALIFORNIA:** For your protection California law requires the following warning statement to appear on this form: 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.

**COLORADO:** WARNING: any person who knowingly and with intent to defraud an insurer provides false, incomplete or misleading information is subject to criminal and civil penalties, including imprisonment, fines and denial of insurance. Any agent who knowingly and with intent to defraud a policyholder or claimant provides false, incomplete or misleading information with regard to a settlement or insurance proceeds payable will be reported to the Colorado Insurance Department.

**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.

**INDIANA, MINNESOTA:** Your state requires us to notify you that: any 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.

**MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 HAMPSHIRE:** Your state requires us to notify you that any person, 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 under New Hampshire law.

**NEW JERSEY, PENNSYLVANIA:** NOTICE: 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.

**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.

**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 with the penalty of 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.

**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.

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## Authorization to Obtain Medical/Confidential Information

Conforms to HIPAA Privacy Rule

### 1. My Information – the individual who is the subject of the information

|              |               |                        |
|--------------|---------------|------------------------|
| Printed Name | Date of Birth | Social Security Number |
| Address      | City          | State Zip              |

### 2. Disclosing Party – parties authorized to release information about me

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency or my employer

### 3. Description of my information authorized for release

- Any information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse; and
- Any information regarding my past, present or future employment that is reasonably necessary to process and administer my claim(s) for accident insurance and/or disability income insurance benefits.

### 4. Purpose of Authorization – how my information will be used

To administer benefits under a policy or certificate of insurance.

### 5. Duration of Authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: \_\_\_\_\_

### 6. Receiving Parties – parties authorized to receive information about me

CNO Services, LLC on behalf of one or more of the following insurance companies: Bankers Life and Casualty Company, Bankers Conesco Life Insurance Company\*, Colonial Penn Life Insurance Company, Wilcac Life Insurance Company, Conesco Life Insurance Company of Texas, Washington National Insurance Company, Primerica Life Insurance Company, Jefferson National Life Insurance Company \*domiciled in and licensed in the State of New York

### 7. Important information – review carefully before signing

- Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
- This Authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: Customer Service P.O. Box 2024, Carmel, IN 46082-2024.
- The Receiving Parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I have a right to a copy of this Authorization, and that a photocopy or facsimile is as valid as the original.
- California residents are entitled to a large print version of this form by calling 800-541-2254 to request form HEALTHMEDAUTH-LARGE.

### 8. Approval – must be signed and dated by me or my Legal Representative\* to be valid

|              |                             |
|--------------|-----------------------------|
| Printed Name | Relationship to the Insured |
| Signature    | Date Signed                 |

\*Legal Representatives must provide documentation of legal authority

Customer Service P.O. Box 2024 Carmel IN 46082-2024 – FAX 317-208-8656 – PH 800-541-2254



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# ACCIDENTAL INJURY CLAIM FORM PHYSICIAN'S STATEMENT

## SECTION B: PHYSICIAN'S STATEMENT Please answer each question COMPLETELY.

Failure to complete all sections may result in a delay in processing this claim.

Policy/Certificate Number: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

|  |                     |                       |                      |                       |  |
|--|---------------------|-----------------------|----------------------|-----------------------|--|
| PHYSICIAN'S NAME   |                     | PHONE NUMBER<br>( )   |                      | FAX NUMBER<br>( )     |  |
| MAILING ADDRESS  |                     | CITY                  |                      | STATE ZIP             |  |
| We need standard claim forms (UB04, CMS1500, etc) to consider benefits; please send bills with this form. If these forms are not available, please complete the following section: |                     |                       |                      |                       |  |
| DATES OF SERVICE   | Diagnosis Code/ICD9 | Diagnosis Description | Procedure Code (CPT) | Procedure Description |  |
|  |                     |                       |                      |                       |  |
|  |                     |                       |                      |                       |  |
|  |                     |                       |                      |                       |  |
|  |                     |                       |                      |                       |  |

1. Where did this accident occur? ☐ HOME ☐ WORK ☐ OTHER Date of incident: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. To your knowledge, has this patient ever had the same or similar medical condition? ☐ YES ☐ NO Dates: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Please describe where and how this accident occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Was patient hospitalized as a result of this diagnosis? ☐ YES ☐ NO Date of admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_
6. If hospitalized, was patient confined to the Intensive Care Unit? ☐ YES ☐ NO Dates of confinement in ICU: \_\_\_\_\_
7. Is patient's past medical history on file in your office? ☐ YES ☐ NO If yes, what years are available? \_\_\_\_\_
8. Please provide the names, addresses, and phone numbers of any physicians who has treated the patient in the last 2 years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature

Date

Tax ID Number

