Helpful Hints

From the Claims Department to guide you through filing your Disability 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.)

TOP 3 REASONS CLAIMS MAY BE DELAYED

1. *Policy* or *certificate number* is not shown on the claim form and/or supporting documents.
2. *Supporting documents* such as the accident report, medical bills, death certificate, etc. are not sent with the claim form.
3. Physician's or Employer's statements are not completed in their *entirety*.

WHERE TO SUBMIT CLAIMS

Mail all disability *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.

Please note: Explanation of Benefits (EOBs) from another insurance company cannot be used to support your claim. Copies of the original bills must be submitted.

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DISABILITY CLAIM FORM

FORM TO BE USED FOR DISABILITY DUE TO ACCIDENT, SICKNESS, AND CONTINUATION OF CURRENT DISABILITY CLAIM

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

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

Filing claim form: ☐ Disability due to accident ☐ Disability due to sickness ☐ Continuation of disability claim

POLICY OR CERTIFICATE NUMBER: _____

SECTION A: OWNER INFORMATION (Please print)

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	BIRTH DATE __/__/__	PHONE NUMBER (HOME) ( )
ADDRESS	☐ 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) ( )	
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 ( )

☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED ☐ OTHER	RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ CHECK IF DEPENDENT IS FULL-TIME STUDENT ☐ CHECK IF INSURED IS DECEASED – DATE DECEASED __/__/_____

IF MAILING ADDRESS IS A PO BOX, PLEASE INDICATE PHYSICAL ADDRESS HERE:

PLACE OF EMPLOYMENT	PHONE NUMBER (WORK) ( )

Please provide the names, addresses and phone numbers of any physician who has treated you or with whom you have consulted in the last five years:

If your disabilty is due to an accident, please describe where and how this accident occurred; please also include the date/dates of the accident:

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

Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

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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: 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.

DICF01(08/21)

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 Conseco Life Insurance Company*, Colonial Penn Life Insurance Company, Wilcac Life Insurance Company, Conseco 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*

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DISABILITY CLAIM FORM
DISABILITY DUE TO ACCIDENT OR SICKNESS

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

SECTION B: EMPLOYER'S DISABILITY STATEMENT. To be completed by employer.

Is claimant self-employed? ☐ YES ☐ NO

EMPLOYEE'S LAST NAME	EMPLOYEE'S FIRST NAME	EMPLOYEE'S DATE OF BIRTH _____/_____/_____
MAILING ADDRESS	CITY	STATE ZIP
EMPLOYER'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
ADDRESS	CITY	STATE ZIP
DATE OF HIRE: _____/_____/_____	FIRST DATE OF DISABILITY: _____/_____/_____	
Date Returned (or expected to return to full time duty): _____/_____/_____		
Is person still employed? ☐YES☐ NO	If no longer employed, last date of employment: _____/_____/_____	
Prior to disability, number of hours worked per week: _____	Monthly Gross Income (Prior to disability): $_____	
Was disability caused by an incident that occurred at the workplace? ☐YES ☐ NO		
Did the incident that occurred happen in the course of performing the employee's job duties? ☐YES ☐ NO		
Has employee returned to work? ☐YES ☐ NO	If yes, is employee working: ☐Full time ☐Part Time ☐Light Duty	
Date employee began light duty: _____/_____/_____		
Is the employee currently earning a pre-disability salary? ☐YES ☐ NO		
Are sickness disability riders or short-term disability premiums paid by the employer with pre-tax dollars? ☐YES ☐ NO If yes, ☐Rider ☐ Short-Term Disability		
Does employer pay a portion of the disability premium for the employee? ☐YES ☐ NO	If yes, what percent? _____%	
Employee is (Check all that apply)	☐Exempt from Social Security ☐ Exempt from Medicare ☐Subject to RRTA ☐ Section 125	

_____ _____ _____

EMPLOYER'S SIGNATURE TITLE DATE

Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

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DISABILITY CLAIM FORM
DISABILITY DUE TO ACCIDENT

SECTION C: 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 ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP

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. Did the incident that occurred happen in the course of performing the employee's job duties? □YES □ NO
3. To your knowledge, has this patient ever had the same or similar medical condition? □YES □ NO Dates: ____/____/____
4. Please describe where and how this accident occurred:

_____
_____
_____

5. Was patient hospitalized as a result of this diagnosis? □YES□ NO Date of admission: ____/____/____ Discharge:___/___/___
6. Hospital Name: _____ City:_____ State:_____
7. **If hospitalized, was patient confined to the Intensive Care Unit? □YES□ NO Dates of confinement in ICU**: _____
8. Is patient's past medical history on file in your office? □YES□ NO If yes, what years are available? _____
9. Is patient □Totally Disabled OR □ Partially Disabled Date patient was released to return back to work: ____/____/____
10. Please provide the names, addresses, and phone numbers of any physicians who has treated the patient in the last 5 years:

_____
_____
_____

_____ _____ _____
Physician's Signature **Date** **Tax ID Number**

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DISABILITY CLAIM FORM
DISABILITY DUE TO SICKNESS

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

Policy/Certificate Number: _____ Policyholder Name: _____
Patient Name: _____ Patient's Date of Birth:_____

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

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP
PRIMARY/FAMILY PHYSICIAN'S NAME	PHONE NUMBER ( )	TAX ID #
MAILING ADDRESS	CITY	STATE ZIP

DATES OF SERVICE	Diagnosis Code/ICD9	Diagnosis Description	Procedure Code (CPT)	Procedure Description

1. To your knowledge, has this patient ever had the same or similar medical condition? □YES □NO Dates: ____/____/____
2. Did the incident that occurred happen in the course of performing the employee's job duties? □ YES □ NO
3. Describe any other disease or infirmity affecting present condition:
4. Please list patient's last known weight:_____ Height:_____
5. Was patient hospitalized as a result of this diagnosis? □ YES □ NO Date of admission: ____/____/____ Discharge:___/___/___
6. Hospital Name: _____ City:_____ State:_____
7. **If hospitalized, was patient confined to the Intensive Care Unit? □YES□ NO Dates of confinement in ICU**: _____
8. Is patient □ Totally Disabled OR □ Partially Disabled First date of disability ___/___/___ End date of disability ___/___/___
9. Please list the objective disability factors (disabling signs & symptoms):_____
   _____
   _____
   _____
   -If length of this disability period exceeds normal duration for this diagnosis, please attach supporting documentation.
10. Is patient's past medical history on file in your office? □YES □NO If yes, what years are available? _____
11. Please provide the names, addresses, and phone numbers of any physicians who has treated the patient in the last 5 years:
    _____
    _____
    _____

_____ _____ _____
Physician's Signature **Date** **Tax ID Number**

Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656

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DISABILITY CLAIM FORM
CONTINUING DISABILITY

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

Policy/Certificate Number: _____ Policyholder Name: _____
Patient Name: _____ Patient's Date of Birth:_____

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

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP
NAME OF STAFF COMPLETING FORM	TITLE	

Is patient disabled? ☐YES ☐ NO **If yes, proceed to questions below**

Is patient ☐ Totally Disabled OR ☐Partially Disabled Date patient was released to return back to work: ____/____/____		
Please provide Diagnosis code that corresponds with the current reason for disability_____		
FIRST DATE OF DISABILITY ____/____/____	FIRST DATE OUT OF WORK ____/____/____	LAST DATE OF TREATMENT ____/____/____
Is patient able to work? ☐YES ☐ NO	If yes, ☐Full time ☐Part Time ☐Light Duty	
If patient has not been released to return to work or if patient is working light duty, please provide next appointment date: ____/____/____		

If you reside in the states of ID, NC or TN, please answer the following questions:

Pregnancy claims: Date of Delivery ____/____/____	☐Normal ☐Cesarean ☐ Non-elective Cesarean	If not delivered, expected delivery date: ____/____/____

_____ _____ _____
Physician's Signature **Date** **Tax ID Number**

Claims Department, P.O. Box 2024, Carmel IN 46082-2024
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DISABILITY CLAIM FORM
CONTINUING DISABILITY CLAIM FORM

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

SECTION F: EMPLOYER'S CONTINUING DISABILITY STATEMENT. To be completed by employer.

EMPLOYEE'S LAST NAME	EMPLOYEE'S FIRST NAME	EMPLOYEE'S DATE OF BIRTH _____/_____/_____
MAILING ADDRESS	CITY	STATE ZIP
EMPLOYER'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
ADDRESS	CITY	STATE ZIP
DATE OF HIRE: _____/_____/_____	FIRST DATE OF DISABILITY: _____/_____/_____	
Date Returned (or expected to return to full time duty): _____/_____/_____		
Is person still employed? □YES □ NO Are you self-employed? □YES □ NO	If no longer employed, last date of employment: _____/_____/_____	
Prior to disability, number of hours worked per week: _____	Annual base salary (Prior to disability): $_____	
Was disability caused by an incident that occurred at the workplace? □YES □ NO		
Has employee returned to work? □YES □ NO	If yes, is employee working: □Full time □ Part Time □ Light Duty	
Date employee began light duty: _____/_____/_____		
Is the employee currently earning a pre-disability salary? □YES □ NO		
Are sickness disability riders or short-term disability premiums paid by the employer with pre-tax dollars? □YES □ NO If yes, □Rider □ Short-Term Disability		
Does employer pay a portion of the disability premium for the employee? □YES □ NO	If yes, what percent? _____%	
Employee is (Check all that apply)	□Exempt from Social Security □ Exempt from Medicare □Subject to RRTA □ Section 125	

_____ _____ _____

EMPLOYER'S SIGNATURE TITLE DATE

Claims Department, P.O. Box 2024, Carmel IN 46082-2024
Phone: (800) 541-2254 Fax: (317) 208-8656