Helpful Hints

From the Claims Department to guide you through filing your Wellness Benefit 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.
- This claim form is designed specifically for the wellness benefit that was purchased as part of your policy. If you need to submit claim for a benefit other than the wellness benefit, please submit a claim form for your policy type to our office for consideration.
- If your policy provides one mammogram benefit per calendar year, please mark the appropriate box and indicate the date the mammogram was performed. Please check your policy for specific benefits covered under your policy.

TOP REASON CLAIMS MAY BE DELAYED

Policy or *certificate number* is not shown on the claim form and/or supporting documents.

WHERE TO SUBMIT CLAIMS

Mail all wellness benefit *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.

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

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WELLNESS BENEFIT CLAIM FORM

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

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures. Please complete this form in its entirety. Keep copies of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the address shown below.

POLICY OR CERTIFICATE NUMBER___________________________________

POLICYHOLDER INFORMATION		
POLICYHOLDER'S FIRST NAME:	MIDDLE INITIAL:	POLICYHOLDER'S LAST NAME:
POLICYHOLDER'S BIRTH DATE:	POLICYHOLDER'S ADDRESS:	

PATIENT INFORMATION		
FIRST NAME:	MIDDLE INITIAL:	LAST NAME:
RELATIONSHIP: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child		DATE OF BIRTH: SEX: ☐ Male ☐ Female

WELLNESS EXAM

Wellness Exam Date: ______________________________

☐ Colonoscopy
☐ Virtual colonoscopy
☐ Pap smear – ThinPrep
☐ Pap smear
☐ Breast ultrasound/sonogram
☐ Hemocult stool specimen
☐ CEA (blood test for colon cancer
☐ CA 125 (blood test for ovarian cancer)
☐ Mammogram
☐ Biopsy
☐ Flexible sigmoidoscopy
☐ Thermography
☐ Chest X-ray
☐ PSA (blood test for prostate cancer)
☐ Other

Pap Smear Date: ___________ Mammogram Date: ___________Mammogram Cost: __________

PHYSICIAN INFORMATION		
NAME:	POLICY NUMBER:	
ADDRESS:		
CITY:	STATE:	ZIP:

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.

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*