Group Cancer Insurance

Colonial Life®
Making benefits count.

If diagnosed with cancer, how will you pay for what your health insurance won't?

The risk of developing cancer, unfortunately, is very real.

Nearly everyone has experienced or knows somebody who has experienced a cancer diagnosis in their family. The good news is that cancer screenings and cancer-fighting technologies have gotten a lot better in recent years. However, with advanced technology come high costs. Major medical health insurance is a great start, but even with this essential safety net, cancer sufferers can still be hit with unexpected medical and non-medical expenses.

Cancer coverage from Colonial Life offers the protection you need to concentrate on what is most important — your care.

Features of Colonial Life's Cancer Insurance:

1. Pays benefits to help with the cost of cancer screening and cancer treatment.
2. Provides benefits to help pay for the indirect costs associated with cancer, such as:
   - Loss of wages or salary
   - Deductibles and coinsurance
   - Travel expenses to and from treatment centers
   - Lodging and meals
   - Child care
3. Pays regardless of any other insurance you have with other insurance companies.
4. Provides a cancer screening benefit that you can use even if you are never diagnosed with cancer.
5. Benefits paid directly to you unless you specify otherwise.
6. Flexible coverage options for employees and their families.

This is a brief description of some available benefits.

We will pay benefits if one of the following routine cancer screening tests is performed or if cancer is diagnosed while your coverage is in force.

Cancer Screening Benefit Tests

This benefit is payable once per calendar year per covered person.

- Pap Smear
- ThinPrep Pap Test[1]
- CA125 (Blood test for ovarian cancer)
- Mammography
- Breast Ultrasound
- CA 15-3 (Blood test for breast cancer)
- PSA (Blood test for prostate cancer)
- Chest X-ray
- Biopsy of Skin Lesion
- Colonoscopy
- Virtual Colonoscopy
- Hemoccult Stool Analysis
- Flexible Sigmoidoscopy
- CEA (Blood test for colon cancer)
- Bone Marrow Aspiration/Biopsy
- Thermography
- Serum Protein Electrophoresis (Blood test for Myeloma)

To file a claim for a covered cancer screening/wellness test, it is not necessary to complete a claim form. Call our toll-free Customer Service number, 1.800.325.4368, with the medical information

Inpatient Benefits

- Hospital and Hospital Intensive Care Unit Confinement
- Ambulance
- Private Full-Time Nursing Services
- Attending Physician

Treatment Benefits (In-or Outpatient)

- Radiation/Chemotherapy
- Antinausea Medication
- Blood/Plasma/Platelets/Immunoglobulins
- Experimental Treatment
- Hair Prosthesis/External Breast/Voice Box Prosthesis
- Supportive/Protective Care Drugs and Colony Stimulating Factors
- Bone Marrow Stem Cell Transplant
- Peripheral Stem Cell Transplant

Surgery Benefits

- Surgery Procedures (including skin cancer)
- Anesthesia (including skin cancer)
- Second Medical Opinion
- Reconstructive Surgery
- Prosthesis/Artificial Limb
- Outpatient Surgical Center

Transportation/Lodging Benefits

- Transportation
- Transportation for Companion
- Lodging

Extended Care Benefits

- Skilled Nursing Care Facility
- Hospice
- Home Health Care Service

Waiver of Premium

THIS IS A CANCER ONLY POLICY.

This policy has exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to policy form GCAN-MP and certificate form GCAN-C (including state abbreviations where used, for example GCAN-C-TX.)

[1]*ThinPrep is a registered trademark of Cytyc Corporation.*

Group Cancer 1000 With Additional Benefits

Colonial Life
1200 Colonial Life Boulevard
Columbia, South Carolina 29210
coloniallife.com

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Group Cancer Insurance— Initial Diagnosis of Cancer Rider

Colonial Life®
Making benefits count.

The diagnosis of internal cancer can be an upsetting time. You do not need to add financial worry to what is already a very difficult situation. When you add an Initial Diagnosis of Cancer rider to your group cancer insurance coverage, you add a little more financial protection at the point you or an insured family member is diagnosed with internal cancer—a time before many medical costs are incurred.

Rider Benefits

This rider pays a lump sum benefit for the initial diagnosis of internal (not skin) cancer. Use the benefit any way you choose, such as to help pay for deductibles and coinsurance on your major medical insurance or settle any outstanding debts.

Rider Features

- Guaranteed renewable as long as your cancer insurance policy is in force.
- Covers the same family members as your cancer insurance policy.
- Pays benefits regardless of any other insurance you have with other insurance companies.
- Pays benefits directly to you, unless you specify otherwise.

This rider has exclusions and limitations. For cost and complete details of the coverage, see your Colonial Life benefits counselor. Coverage may vary by state and may not be available in all states. Applicable to rider form R-GCAN-Indx (including state abbreviations where used - for example: R-GCAN-Indx-TX).

Group Cancer 1000— Initial Diagnosis of Cancer Rider

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COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

1200 Colonial Life Boulevard, P. O. Box 1365
Columbia, South Carolina 29202
(800) 325-4368

GROUP SPECIFIED DISEASE INSURANCE

Outline of Coverage

(Applicable to certificate form GCAN-C-TX)

THIS IS LIMITED BENEFIT GROUP SPECIFIED DISEASE COVERAGE. THE POLICY PROVIDES LIMITED BENEFITS FOR CANCER AND CANCER SCREENING PROCEDURES. THE POLICY DESCRIBED IN THIS OUTLINE PROVIDES SUPPLEMENTAL COVERAGE ISSUED ONLY TO SUPPLEMENT INSURANCE ALREADY IN FORCE.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.
If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

Read your certificate carefully. This outline provides a very brief description of the important features of the Group Specified Disease Insurance certificate. This is not an insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of the policyholder, you and us. The certificate is a summary of the policy and is a written statement, including the certificate schedule, prepared by us to set forth a summary of benefits to which the covered person is entitled, to whom the benefits are payable, and limitations or requirements that may apply and amendments, riders and supplements, if any. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY.

The certificate provides benefits if the first date of diagnosis of cancer or the performance of a cancer screening test occurs: while the certificate is in force; and if the cancer or treatment is not excluded by name or specific description in the policy or certificate. Cancer must be pathologically or clinically diagnosed. If cancer is not diagnosed until after the covered person dies, we will only pay benefits for the treatment of cancer performed during the 45 day period before the covered person's death.

Benefits

$50 Cancer Screening/Wellness Benefit

We will pay this benefit if any covered person has one of the following cancer screening tests performed while his coverage is in force. This benefit is payable once per calendar year for each covered person.

Cancer screening test is defined as:

• Biopsy of skin lesion; • Bone marrow aspiration/biopsy; • Breast ultrasound; • CA 15-3 (blood test for breast cancer); • CA125 (blood test for ovarian cancer); • CEA (blood test for colon cancer); • Chest X-ray; • Colonoscopy;	• Flexible sigmoidoscopy; • Hemoccult stool analysis; • Mammography; • Pap smear; • PSA (blood test for prostate cancer); • Serum Protein Electrophoresis (blood test for myeloma); • Thermography; • ThinPrep Pap test; • Virtual Colonoscopy.

Hospital Confinement/ Hospital Intensive Care Unit Confinement	**$100 per day for first 30 days of hospital in a calendar year** **$200 per day for hospital confinement after the first 30 days of hospital confinement in a calendar year** **$200 per day for hospital intensive care unit confinement** **Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.**

We will pay the applicable benefit shown above for each day any covered person incurs charges for hospital confinement or hospital intensive care unit confinement for the treatment of cancer up to the 180-day maximum per calendar year.

Hospital Confinement/ Hospital Intensive Care Unit Confinement in U.S. Government Hospital	**$100 per day for first 30 days of hospital confinement in a calendar year** **$200 per day for hospital confinement after a the first 30 days of hospital confinement in a calendar year** **$200 per day for hospital intensive care unit confinement** **Maximum benefit of 180 days per calendar year for hospital confinement and hospital intensive care unit confinement combined.**

We will pay the applicable benefit shown above for each day any covered person is confined in a U.S. Government hospital or a U. S. Government hospital intensive care unit for the treatment of cancer up to the 180-day maximum per calendar year.

Ambulance **$100 per trip**

We will pay this benefit for each trip any covered person makes if a professional ambulance service transports him to or from a hospital where he is confined as an inpatient for the treatment of cancer. He must incur charges for a professional ambulance service to receive this benefit. We will pay for no more than two one-way trips each time he is confined as an inpatient for the treatment of cancer.

Private Full-Time Nursing **$100 per day**

We will pay this benefit for each day any covered person incurs charges for and uses private full-time nursing services required and authorized by his doctor while he is confined to a hospital for the treatment of cancer. Private full-time nursing must be performed by a registered, a licensed practical or a licensed vocational nurse.

Attending Physician **$50 per day up to a maximum of 180 days per calendar year**

We will pay this benefit if any covered person incurs charges for and uses the services of an attending physician while confined to a hospital for the treatment of cancer. An *attending physician* is a doctor, other than the covered person's surgeon, who performs services for him while confined to a hospital.

Radiation/Chemotherapy **$150 a day up to a maximum of $5,000 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives one or more of the following treatments for the purpose of the destruction of malignant cells during the treatment of internal (not skin) cancer up to the calendar year maximum: teleradiotherapy, using either natural or artificially propagated radiation; interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources; or chemical substances that have a cancercidal effect (chemotherapy). Radiation and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration. We will not pay for office visits, laboratory tests, diagnostic X-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other procedures related to these treatments.

Antinausea Medication **$50 a day up to a maximum of $200 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives antinausea medication administered in a doctor's office, clinic or hospital or has a prescription filled for antinausea medication as a result of radiation or chemotherapy treatments, up to the calendar year maximum. We will pay only one Antinausea Medication benefit per day regardless of the number of antinausea medications the covered person receives on the same day.

Blood, Plasma, Platelets and Immunoglobulins **$150 per day, up to a maximum of $5,000 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and receives a transfusion of blood/plasma/platelets/immunoglobulins during the treatment of cancer, up to the calendar year maximum.

Experimental Treatment **$300 per day up to $10,000 lifetime maximum**

We will pay this benefit for each day that any covered person incurs charges for and receives hospital, medical or surgical care in connection with experimental treatment of internal (not skin) cancer. These treatments must be prescribed by a physician and must be received in an experimental cancer treatment program. Treatment must be received in the United States. Payment of this benefit is in place of payment of any other benefit for the same covered treatments.

Hair/External Breast/Voice Box Prosthesis **$200 per calendar year**

We will pay this benefit if any covered person incurs charges for and receives a hair prosthesis, external breast prosthesis or voice box prosthesis needed as a direct result of cancer.

Supportive or Protective Care Drugs and Colony Stimulating Factors **$100 per day up to $800 calendar year maximum**

We will pay this benefit for each day that any covered person incurs charges for and receives supportive or protective care drugs and/or colony stimulating factors for the treatment of cancer, up to the calendar year maximum.

Bone Marrow Stem Cell Transplant **$10,000 per lifetime**

We will pay this benefit if any covered person incurs charges for and receives a bone marrow stem cell transplant for the treatment of cancer. We will pay this benefit only once per lifetime for each covered person.

Peripheral Stem Cell Transplant **$5,000 per lifetime**

We will pay this benefit if any covered person incurs charges for and receives a peripheral stem cell transplant for the treatment of cancer. We will pay this benefit only once per lifetime for each covered person.

Transportation **$0.40 per mile up to 700 miles per round trip**

We will pay this benefit if: any covered person travels on his doctor's advice to another city for diagnosis or treatment of his cancer; the destination is more than 50 miles one way from the city where he lives; and he is receiving treatment for internal (not skin) cancer. We will pay this benefit when charges are incurred for travel to and from his destination for either: commercial travel (plane, train or bus); or non-commercial travel (use of a personal car).

Transportation for Companion **$0.40 per mile up to 700 miles per round trip**

We will pay this benefit for one companion to accompany any covered person to another city where he is receiving treatment for cancer if: his doctor advises treatment or diagnosis of his cancer in another city; the destination is more than 50 miles one way from the city where he lives; and he is receiving treatment for internal (not skin) cancer.

We will pay this benefit when charges are incurred for travel to and from any covered person's destination for either: commercial travel (plane, train or bus); or non-commercial travel (use of personal car).

Lodging **$50 per day up to 70 days maximum per calendar year**

We will pay this benefit for each day any covered person or any adult companion incurs charges for lodging required while the covered person is being treated for cancer more than 50 miles from his residence. We will pay for up to 70 days per calendar year.

Surgery **$30 per surgical unit up to $1,500 per procedure**

We will pay this benefit if any covered person incurs charges for and has a surgical procedure performed by a doctor for treatment of cancer up to the maximum benefit amount.

Anesthesia **25% of the amount of the Surgery benefit paid**

We will pay this benefit if any covered person incurs charges for and receives general anesthesia administered by an anesthesiologist or a Certified Registered Nurse Anesthetist during a surgical procedure that is performed for the treatment of cancer.

$25 per procedure – We will pay this benefit if any covered person incurs charges for and receives local anesthesia during a surgical procedure performed for the treatment of cancer and for which a benefit is payable under this certificate.

Second Medical Opinion **$300 per malignant condition**

We will pay this benefit if any covered person incurs charges for and obtains a second medical opinion from another doctor on recommended surgery or treatment following the positive diagnosis of internal (not skin) cancer. We will pay this benefit only once for each cancerous condition.

Reconstructive Surgery **$30 per surgical unit up to a maximum of $1,500 per procedure, including general anesthesia**

We will pay this benefit if a covered person incurs charges for a reconstructive surgery that: requires an incision; is performed by a doctor for treatment of cancer; and is due to internal (not skin) cancer. We will pay for no more than two surgeries per site.

If the Reconstructive Surgery benefit is less than the maximum benefit amount allowed for this benefit, then we will also pay up to 25% of the Reconstructive Surgery benefit amount if a covered person incurs charges for and has general anesthesia administered during surgery. For the purposes of this provision, reconstructive surgery includes, but is not limited to, surgical procedures performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Prosthesis/Artificial Limb **$2,000 per device or artificial limb up to a $4,000 lifetime maximum**

We will pay this benefit if any covered person incurs charges for a surgically implanted prosthetic device or artificial limb needed as a direct result of cancer surgery, up to the lifetime maximum. We will pay for no more than one of the same type of device per site.

Outpatient Surgical Center **$250 a day up to a maximum of $750 per calendar year**

We will pay this benefit for each day any covered person incurs charges for and has surgery at an outpatient surgical center for internal (not skin) cancer, up to the calendar year maximum.

Skilled Nursing Care Facility **$300 per day**

We will pay this benefit for each day any covered person incurs charges for and is confined to a skilled nursing care facility during the treatment of cancer. Confinement must begin within 14 days after the covered person is released from a hospital. We will pay this benefit for no more than the number of days for which we paid the Hospital Confinement/Hospital Intensive Care Unit Confinement benefit or the Hospital Confinement/ Hospital Intensive Care Unit Confinement in a U. S. Government Hospital benefit for his most recent confinement.

Hospice **$300 per day**

We will pay this benefit for each day any covered person incurs charges for and: receives a visit from a representative of a hospice at home; uses the services of a hospital or a U.S. Government Hospital on an outpatient basis under the direction of a hospice; visits a hospice on an outpatient basis for treatment or services as the result of cancer; or is confined to a hospice facility.

Home Health Care Services **$300 per day**

We will pay this benefit for up to the greater of: 30 days per calendar year; or twice the number of days any covered person incurs charges for and was confined to a hospital during a calendar year for the treatment of cancer.

Waiver of Premium

You, the named insured, will not be required to continue to pay premiums to keep your coverage in force if: the first date of diagnosis is while your coverage is in force; and you become disabled, as defined in the certificate, because of cancer after the effective date of your coverage and remain disabled for longer than three continuous months (90 days).

Termination

The policy can be cancelled by the policyholder or us. Your coverage will terminate if the policy terminates, if your premium is not paid, if you are no longer eligible for the coverage or if you ask us to end your coverage. If this is family coverage, coverage on your spouse and dependent children will terminate if the policy terminates, if premium for family coverage is not paid, if your coverage terminates, if you ask us to end their coverage or if you die. In addition, coverage on your spouse will terminate if you divorce your spouse or your marriage is annulled, and coverage on any dependent child will terminate when he no longer qualifies as a dependent child.

Conversion Privilege

If one of the following events occurs:

- your coverage terminates because you are no longer in an eligible class or your class is no longer eligible for coverage, or
- coverage of your spouse under the certificate terminates due to divorce, annulment or your death, or
- coverage of a covered dependent child terminates due to the child becoming married or reaching age 26, or
- coverage of a covered person who has received benefits for the treatment of cancer under the certificate terminates for any reason,

then such covered person may be eligible to obtain an individual policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to certain conditions, including but not limited to:

- Such covered person's coverage under the certificate must have been in effect for 12 months unless such covered person has received benefits for the treatment of cancer under the certificate.
- Application for the converted policy must be made to us within 31 days after the coverage terminates.
- The converted policy may have different benefits, limitations and exclusions and premium rates.
- If you are eligible for a converted policy, any spouse or dependent children covered under the certificate may also be covered under the converted policy. If a spouse is eligible for a converted policy due to divorce or annulment, any dependent children covered under the certificate may also be covered under the converted policy or they may remain covered under the certificate as you and your former spouse may elect. They may not be covered under both the certificate and the converted policy. If a spouse is eligible for a converted policy due to your death, any dependent children covered under the certificate may also be covered under the converted policy.

Definitions

Cancer

Cancer means a disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. Pre-malignant conditions or conditions with malignant potential are not to be construed as cancer for purposes of the certificate. Cancer must be diagnosed by a pathological diagnosis or a clinical diagnosis.

Dependent children

Dependent children means your: natural children, step-children, grandchildren who are your dependents for federal income tax purposes; adopted children; children for whom you are required to insure under a medical support order issued under section 14.061, Family code, or enforceable by a court in this state; children in your custody under a temporary court order that grants you conservatorship of the children. Such children must be: unmarried; chiefly dependent on the named insured or his spouse for support; and younger than age 26.

Pre-existing Condition

Pre-existing Condition means a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the effective date of the coverage and which is not excluded by name or specific description in the certificate.

Skin Cancer

Skin cancer means: melanoma of Clark's Level I or II (Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin.

Pre-Existing Condition Limitation: We will not cover cancer that meets the requirements of the Eligibility for Cancer Benefits provision in the certificate but is a preexisting condition as defined in the certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule. No benefits will be payable for any cancer for which the requirements of the Eligibility for Cancer Benefits provision are not met.

Colonial Life Doctor's Office Visit Claim

FAX this direction	FAX this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia, SC 29202	From:	
		Number of pages:	

File Your Claim Online

- If you are filing a claim for a doctor's office visit within the past 36 months, you may simply log into your account at Coloniallife.com and click the "File an Online Claim" button to begin the process.
- As an added convenience, you may also select Direct Deposit when filing online.
- Not a member? Click on "Register" from Coloniallife.com to become a member. Click on Join the Policyholder Website and follow the instructions to set up the account.

Optional Service Release Agreement

Please indicate below for optional services you desire. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the following individual inquiring on my behalf.
Note: Leave blank if you do not want anyone accessing your claim information.

_____ Sales representative _____ Employer _____ Spouse, family member or significant other Name: _____

_____ **Yes, I want to Direct Deposit all payments into my bank account.** I have enclosed a voided check for a checking account or a deposit slip for a savings account with my initial claim submission. Please note: Allow up to three business days after claim payment for deposit into your account.

I also understand that I must notify Colonial Life to discontinue any of these services.

This form is for Doctor's Office Visit and Prescription Drugs.

If you are filing for other benefits, please use the appropriate claim form.
Incomplete claim form submission may result in a delay in the processing of your claim.

- If your name has changed, attach a copy of legal documentation of the change.
- Dates should be written in month/day/year format (i.e. 12/14/1980).
- Attach a pharmacy detailed receipt or mail order pharmaceutical statement showing the covered person's name, the name of the prescription drug(s) and the prescription(s) fill date.
- Benefits are payable to you unless we receive written authorization to pay them elsewhere. This is called an assignment.
- 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.

Please check the type of claim(s) you are filing: ☐ Doctor Office Visit ☐ Telemedicine ☐ Prescription Drugs (Please refer to your policy to see if prescription drugs is a listed benefit. If yes, please complete prescription section.)

Section 1 – Claimant statement (completed by policy owner)

Claimant name:	☐ Male ☐ Female	DOB: ____/____/_____	SSN:
Relationship to policy owner: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent			
Policy owner information (if other than claimant) — Name:		DOB: ____/____/_____	SSN:
Address:	City:	State:	ZIP:
Email:		Contact number:	

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming require the following statement to appear on this claim form.

Fraud Warning: Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California: Any person who knowingly presents 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: 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.

District of Columbia: 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.

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 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, 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, as provided in RSA 638.20.

New Jersey: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and civil penalties.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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 (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are 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.

Policy owner name:		Policy owner SSN:
If other than policy owner	Claimant name:	Claimant SSN:

Please attach copy of bill(s). Complete one claim form for each claimant for the calendar year.

Date of visit: ____ / ____ / ______ ☐ In Office ☐ Telemedicine (if covered by your policy)	Physician/Facility:	Telephone:	
Address:	City:	State:	ZIP:

Date of visit: ____ / ____ / ______ ☐ In Office ☐ Telemedicine (if covered by your policy)	Physician/Facility:	Telephone:	
Address:	City:	State:	ZIP:

Date of visit: ____ / ____ / ______ ☐ In Office ☐ Telemedicine (if covered by your policy)	Physician/Facility:	Telephone:	
Address:	City:	State:	ZIP:

Date of visit: ____ / ____ / ______ ☐ In Office ☐ Telemedicine (if covered by your policy)	Physician/Facility:	Telephone:	
Address:	City:	State:	ZIP:

Date of visit: ____ / ____ / ______ ☐ In Office ☐ Telemedicine (if covered by your policy)	Physician/Facility:	Telephone:	
Address:	City:	State:	ZIP:

Prescriptions - Refer to your policy. Complete only if your policy covers prescription drugs. Attach copies of receipts for each prescription.

Pharmacy Name/Telephone Number	Date Prescription Filled	Prescription Number
Pharmacy Name/Telephone Number	Date Prescription Filled	Prescription Number
Pharmacy Name/Telephone Number	Date Prescription Filled	Prescription Number
Pharmacy Name/Telephone Number	Date Prescription Filled	Prescription Number
Pharmacy Name/Telephone Number	Date Prescription Filled	Prescription Number

Certification

Policy owner's name: ______________________________ SSN: ______________

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 Statements on page two of this 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.

Fraud Warning: For your protection, Arizona law requires the following to appear on this claim form: Any person who knowingly and with the intent to injure, defraud or deceive an insurance company presents 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.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form: Any person who knowingly and with the intent to defraud any insurance company or other person files and 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

Print claimant's name	Claimant's signature	Date (MM/DD/YYYY)
Print policy owner's name	Policy owner's signature	Date (MM/DD/YYYY)

Authorization for Colonial Life & Accident Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company and its duly authorized representatives (Colonial Life).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. Some information, once 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. Colonial Life will not re-disclose the information unless permitted or required by those laws or as authorized by me.

I also authorize Colonial Life to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Colonial Life; or, the Social Security Administration. Colonial Life will not condition the payment of insurance benefits on whether I authorize Colonial Life to re-disclose my information. For the purposes of these disclosures by Colonial Life, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), 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. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life 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 I do not sign this authorization or if I alter or revoke it, except as specified above, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

_____ _____

Signature | Date signed (MM/DD/YYYY)

_____ XXX-XX-_____ _____

Printed name of individual subject to this disclosure | Last four digits of SSN | Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_____ _____ _____

Printed name of legal representative | Signature of legal representative | Date signed (MM/DD/YYYY)

Colonial Life Health/Wellness Screening Claim

FAX this direction	FAX this form: **1-800-880-9325** Or mail: P.O. Box 100195, Columbia, SC 29202	From:	
		Number of pages:	

File Your Claim Online

- ▶ Simply log into your account at Coloniallife.com and click on "File an Online Claim" button.
- ▶ As an added convenience, you may also select Direct Deposit when filing online.
- ▶ Not a member? Click on "Register" from Coloniallife.com to become a member. Click on "Policyholder" and follow the instructions to set up the account.

Optional Service Release Agreement

I authorize Colonial Life to facilitate processing this claim by releasing its details to the following individual inquiring on my behalf. Any marks used (check mark, X, initials, etc.) will be considered as your authorization and will be processed as if they were selected.
Note: Leave blank if you do not want anyone accessing your claim information.

_____ Sales representative _____ Employer _____ Spouse, family member or significant other Name: _____

I also understand that I must notify Colonial Life to discontinue this service.

Complete each section before submitting your claim. Incomplete claim form submission may result in a delay in the processing of your claim.

- If your name has changed, attach a copy of legal documentation.
- Dates should be written in month/day/year format (i.e. 12/14/1980).
- Social Security number is indicated by SSN.
- Benefits are payable to you unless we receive written authorization to pay them elsewhere. This is called an assignment.
- 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.

Section 1 – Claimant statement (completed by policy owner)

Claimant name:	☐ Male ☐ Female	DOB: ____/____/_____	SSN:
Relationship to policy owner: ☐ Self ☐ Spouse ☐ Domestic partner ☐ Dependent			
Policy owner information (if other than claimant) — Name:		DOB: ____/____/_____	SSN:

Address:	City:	State:	ZIP:
Email:	Contact number:		
Physician/Treating facility:		Telephone:	
Address:	City:	State:	ZIP:

Claim Fraud Statements

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit is issued.

For your protection, state laws, including Alaska, Arizona, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming require the following statement to appear on this claim form.

Fraud Warning: Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly present 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.

California: Any person who knowingly presents 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: 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.

District of Columbia: 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.

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 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, 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, as provided in RSA 638.20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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 (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are 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.

Policy owner name:		**Policy owner SSN:**
If other than policy owner	**Claimant name:**	**Claimant SSN:**

Type of screening test performed — complete one claim form for each claimant for each calendar year

- You must attach a copy of the bill(s) for each test. The bill(s) must include the facility/physician's name and telephone number.
- Review your policy or policies for the list of covered tests prior to completing this form.
- Most policies do not pay for routine physical examinations. Review your policy to determine whether this benefit is included.
- Most policies provide one health/wellness screening benefit per calendar year (refer to your policy for details).
- Fill in the date of the test you had performed below.

TEST	DATE (MM/DD/YYYY)
Blood glucose	____ /____ /____
Bone marrow aspirate/biopsy	____ /____ /____
BRCA 1	____ /____ /____
BRCA 2	____ /____ /____
Breast ultrasound	____ /____ /____
CA125 (ovarian cancer)	____ /____ /____
CA 15-3 (breast cancer)	____ /____ /____
Cancer vaccine	____ /____ /____
Carotid Doppler	____ /____ /____
CEA (colon cancer)	____ /____ /____
Cholesterol (HDL /LDL /lipids)	____ /____ /____
Chest X-ray	____ /____ /____
Colonoscopy	____ /____ /____

TEST	DATE (MM/DD/YYYY)
Echocardiogram (Echo)	____ /____ /____
Electrocardiogram (EKG/ECG)	____ /____ /____
Hemoccult stool analysis	____ /____ /____
Immunizations (excludes flu and allergy shots)	____ /____ /____
Mammogram (breast)	____ /____ /____
Pap smear/thin prep pap (GYN)	____ /____ /____
PSA (prostate)	____ /____ /____
Serum protein (myeloma)	____ /____ /____
Skin biopsy	____ /____ /____
Sigmoidoscopy	____ /____ /____
Stress test (bicycle/treadmill)	____ /____ /____
Thermography	____ /____ /____
Triglycerides	____ /____ /____

Please review your policy to determine if an annual physical is covered. If covered, provide date of annual physical. Date: ____ /____ /____

Certification

Policy owner's name: _____ SSN: _____

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 Statements on page two of this 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.

Fraud Warning: For your protection, Arizona law requires the following to appear on this claim form:
Any person who knowingly and with the intent to injure, defraud or deceive an insurance company 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.

Fraud Warning: For your protection, New York law requires the following to appear on this claim form:
Any person who knowingly and with the 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes the Physician Statement portion of the claim form.

Print claimant's name	Claimant's signature	Date (MM/DD/YYYY)
Print policy owner's name	Policy owner's signature	Date (MM/DD/YYYY)

Authorization for Colonial Life & Accident Insurance Company

Sign and return this authorization to Claims Department at the address listed above. This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company and its duly authorized representatives (Colonial Life).

Health information may be disclosed by any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Non-health information may be disclosed by any entity, person or organization that has any records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, consumer reporting agencies including credit bureaus, professional licensing bodies, attorneys or governmental entities.

Health information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, information on the diagnosis, treatment, and testing results related to sexually transmitted diseases, unless further restricted by state law, use of drugs or alcohol, mental or physical history, condition, advice or treatment, but does not include psychotherapy notes. Non-health information, includes earnings, financial or credit history, professional licenses, employment history or any other facts deemed necessary by Colonial Life to evaluate my application or claim forms.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits or for evaluating my eligibility for insurance, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms. Some information, once 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. Colonial Life will not re-disclose the information unless permitted or required by those laws or as authorized by me.

I also authorize Colonial Life to disclose my information to the following persons (for the purpose of reporting claim status, or experience, or so that the recipient may carry out health care operations, claims payment, administrative or audit functions related to any benefit, plan or claim): any employee benefit plan sponsored by my employer; any person providing services or insurance benefits to (or on behalf of) my employer, any such plan or claim, or any benefit offered by Colonial Life; or, the Social Security Administration. Colonial Life will not condition the payment of insurance benefits on whether I authorize Colonial Life to re-disclose my information. For the purposes of these disclosures by Colonial Life, this authorization is valid for one year or for the length of time otherwise permitted by law.

This authorization is valid for two (2) years from its execution or the duration of my claim (to include any subsequent financial management and/or benefit recovery review), 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. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life 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 I do not sign this authorization or if I alter or revoke it, except as specified above, Colonial Life may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to the Claims Department at the address listed above.

_____ _____

Signature | Date signed (MM/DD/YYYY)

_____ XXX-XX-_____ _____

Printed name of individual subject to this disclosure | Last four digits of SSN | Date of birth (MM/DD/YYYY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

_____ _____ _____

Printed name of legal representative | Signature of legal representative | Date signed (MM/DD/YYYY)