Cancer Claim Statement

ASSURANT Employee Benefits®

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in the states of Alaska or Oregon, the following statement applies to you:
A person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

If you live in the states of Arizona or New Jersey, the following statement applies to you:
A person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

If you live in the states of Arkansas, Louisiana or Maryland, the following statement applies to you:
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.

If you live in the state of California, the following statement applies to you:
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.

If you live in Colorado, the following statement applies to you:
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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

If you live in Delaware, Florida, Idaho, Indiana or Oklahoma, the following statement applies to you: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony. In Florida, it is a felony of the third degree.

If you live in the District of Columbia, Tennessee or Virginia, the following statement applies to you:
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.

If you live in New Hampshire, the following statement applies to you:
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.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms “we,” “us,” “our,” and the like, refer to each as applicable.

Listed below is our Benefit Center and corresponding address, toll-free number, fax number and E-mail :
Assurant Employee Benefits (Home Office) PO Box 419568 Kansas City Missouri 64141-6568 • T 800.451.4531 • F 816.474.2320
KCBenefitCenter@assurant.com

If you live in New York the following statement applies to you:

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 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.

If you live in Minnesota, the following statement applies to you:

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

If you live in Texas, the following statement applies to you:

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.

If you live in a state other than mentioned above, the following statement applies to you:

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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Insured Employee Instructions for filing a Cancer Claim

1. Complete Part 1 and Part 4.
2. Complete Part 2 or Part 3 if filing for a dependent.
3. Have the physician complete Part 5.
4. Sign and date the Authorization Sections.
5. Provide Documentation:

   Attach itemized bill or medical insurance Explanation of Benefits (EOB) for each charge to be considered. Some documentation can be obtained by requesting a copy of the hospital bill (UB04) or HCFA1500 (non-hospital bill) from your healthcare provider.

   Please include the following documents for all that apply:
   Hospital: copy of hospital bill indicating diagnosis, treatment, services and days hospitalized
   Surgical: a copy of the operative report
   Medical: a copy of medical bills indicating the treatment received and/or services rendered
   Ancillary: a copy of bills for ambulance, lodging, transportation, or other care or covered services

   Cancer Screening Benefit: *See policy for covered tests or procedures.* If only submitting a claim for this benefit you can use the **Employee Paid Supplemental Claim Form** or complete part 1 (also part 2 if for spouse) and part 4 of this form and attach proof of the test or procedure that includes the date of service and place of service.

HIPAA Authorization For Release of Protected Health Information

ASSURANT Employee Benefits®

Insured/Member name _____ SSN _____ DOB _____

Claimant name _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, insurance company, pharmacy, pharmacy benefits manager, or any pharmacy-related services entity, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of mine.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company of New York ("Companies").

I hereby authorize the use or disclosure of my protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies or its representatives to determine my eligibility for benefits and to process my claim. Such information may include, but is not limited to: Any and all medical/ dental records relating to my physical and/or mental health whether for treatment or evaluation purposes, pharmacy records, and strength/functional testing.

The sole purpose of this disclosure is for the adjudication of my claim for insurance benefits under the above-referenced Policy.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only - we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be disclosed to or used by the insured member under the above policy.
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until my claim ends.

_____ _____

SIGNATURE OF CLAIMANT OR LEGAL REPRESENTATIVE | DATE

_____ _____

PRINTED NAME OF LEGAL CLAIMANT REPRESENTATIVE | RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please mail or fax your Authorization to the address listed below:

Cancer Claim Statement

ASSURANT Employee Benefits®

Part 1 – To be completed by Insured Employee *(Please print or type.)*

Full name *(As it appears on your Social Security card.)*	Policy number
Employer name	Employer phone number

This claim is being filed for: ☐ Self ☐ Spouse Sex: ☐ Male ☐ Female

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Date of birth	Social Security number	Home phone number

Street address	City	State	Zip

Mobile phone number	E-mail address

Part 2 – To be completed by spouse if benefits are for spouse *(Please print or type.)*

Full name (As it appears on your Social Security card.)	Sex: ☐ Male ☐ Female

Date of birth	Social Security number	Mobile phone number

Part 3 – Complete for dependent if benefits are for dependent *(Please print or type.)*

Full name (As it appears on your Social Security card.)	Sex: ☐ Male ☐ Female

Date of birth	Married? ☐ Yes ☐ No	Social Security number	Mobile phone number

If over age 19, but less than 25, full-time student? ☐ Yes ☐ No
If "Yes," attach copy of recent semester grade report.

Name of school	School administration phone

Street address	City	State	Zip

If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority and sign below.

Signature _____ Relationship to claimant _____

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Claimant's signature _____ Date _____

Part 4 – Claim Information*(Please print or type. If necessary, attach separate sheet.)*

This ☐ Initial ☐ Recurrent claim is for

Primary physician name	Phone
Primary physician address	
Hospital name	Phone
Hospital address	
Date when cancer was first diagnosed	

Benefits will be based on the current level of benefits elected. See policy for details.

Level 1 and 2 Items *(Check all that apply.)*

- ☐ Hospital confinement
- ☐ Radiation and chemotherapy
- ☐ In/Out hospital blood and plasma
- ☐ Extended-care facility
- ☐ Hospice
- ☐ In-hospital doctor visits
- ☐ Post-hospital doctor visits
- ☐ Prosthesis
  - ☐ Surgically implanted devices
  - ☐ Other devices
- ☐ Ambulance service
- ☐ Lodging
- ☐ Second surgical opinion
- ☐ Skin cancer
- ☐ Surgery and general anesthesia

Level 2 Items *(Check all that apply.)*

- ☐ First occurrence
- ☐ Alternative Care
  - ☐ Integrative/Education
  - ☐ Palliative Care
  - ☐ Lifestyle Benefit
- ☐ Experimental treatment
- ☐ Medical imaging
- ☐ National Cancer Institute evaluation/consultation
- ☐ Anti-nausea medication
- ☐ Bone marrow transplant
  - ☐ Insured
  - ☐ Donor
- ☐ Stem cell transplant
- ☐ Immunotherapy
- ☐ Home health care
- ☐ Nursing services
- ☐ Transportation
- ☐ Reconstructive surgery
- ☐ Outpatient hospital surgical

Cancer Screening Benefit: *See policy for covered tests or procedures.* If only submitting a claim for this benefit you can use the **Employee Paid Supplemental Claim Form** or complete part 1 (also part 2 if for spouse) and part 4 of this form and attach proof of the test or procedure that includes the date of service and place of service.

☐ Colonoscopy	☐ CA 125 test	☐ Chest x-ray	☐ Flexible sigmoidoscopy
☐ Mammogram	☐ Pap smear	☐ Biopsy	☐ PSA
☐ CT scans or MRI scans	☐ BRCA testing	☐ Hemocult stool specimen	

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

Part 5 – Physician's Statement - ***This statement must be filled in completely by a physician. (Please print or type.)***

Date symptoms first appeared	Diagnosis	Date of diagnosis	ICD-9 code

Has this patient been treated for this same or similar condition prior to this occurrence? ☐ Yes ☐ No

If "Yes," please provide diagnosis, the dates of treatment and names of other medical providers.

Provide the name, address and phone number of any referring physicians.

To your knowledge, has your patient used tobacco products in the past 12 months? ☐ Yes ☐ No

Are you the parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the patient? ☐ Yes ☐ No

For services related to a hospitalization, please provide the following. *(Please print or type.)*

Name of hospital				
Street address of hospital	City	State	Zip	Phone

Admission date	Discharge date

Physician's Information *(Please print or type.)*

Name	Degree	Specialty/Board Certification		
Street address	City	State	Zip	

Phone	Fax	Physician's EIN or SSN

Physician's signature	Date

DO NOT PRE-DATE