



CANCERCARE INSTRUCTIONS FOR FILING CLAIMS

Dear Policyholder:

Thank you for choosing USABLE Life to provide your protection against the increasing costs of cancer treatment. We have included these instructions to assist you in the event you need to file a claim. You can obtain claim and authorization to release medical forms from our website at www.usablelife.com or contact a Personal Account Representative at the phone number listed below. **Please remember claims must be received within 90 days of diagnosis of cancer, ICU/CCU admission, or date of mammogram or diagnostic tests.**

CANCER OR SPECIFIED DISEASE CLAIMS

1. Complete and sign the Insured's Statement on the Cancer and Specified Disease Benefits claim form, CL-CSD.
2. Answer **ALL** questions, or state "not applicable". Incomplete forms will be returned.
3. Have your physician complete the Attending Physician's Statement. Be sure **ALL** questions are answered and the form is signed.
4. Attach itemized bills for all treatment. We are sorry, but we cannot accept billing summaries or Explanations of Benefits from other insurance claims.
5. Sign and return the Authorization for Release of Medical Records form.

HOSPITAL CORONARY/INTENSIVE CARE CONFINEMENT BENEFITS - *Rider Only*

1. Complete and sign the Insured's Statement on the Coronary Care or Intensive Care claim form CL-HIP/ICU-CCU. Answer **ALL** questions or state "not applicable". Incomplete forms will be returned.
2. Have your physician complete the Attending Physician's Statement. Be sure **ALL** questions are answered and the form is signed.
3. Attach itemized hospital bill. We are sorry but we cannot accept billing summaries or Explanations of Benefits from other insurance claims.
4. Sign and return the Authorization for Release of Medical Records form.

Note: This form should be completed only for ICU/CCU confinement from an accident or non-cancer or specified disease. ICU/CCU confinement for cancer and specified disease claims should be filed on Form CL-CSD.

WELLNESS BENEFITS

1. Please mail us an ITEMIZED bill for the covered test or service. Payment will be mailed to the address on the bill. Please make sure this address is correct. (Do not rely on your physician or hospital to file your claim.) You can also obtain instructions on how to file wellness claims on our website.
2. You do NOT need a claim form or Authorization to Release Medical Records form to collect reimbursement for these benefits BUT the following information must be submitted:
 - Insured's Name and Social Security Number
 - Policy Number (very important)
 - Patient's Name, Date of Birth, and Social Security Number
 - Date of Service
 - Current mailing addressYou may write the above on the itemized bill for submission.
3. Incomplete claims cannot be processed and will be returned to you.

Mail Claim Forms and Bills To:
Claim Department
USABLE Life
P.O. Box 1650
Little Rock, AR 72203-1650
Cancer Claim Fax: (501) 235-8416
Wellness Claim Fax: (501) 235-8400
Email: claims@usablelife.com

For Questions or Assistance Contact:
Personal Account Representative
USABLE Life
1-800-370-5856
8:00 a.m. - 4:30 p.m. Central Time
Email: custserv@usablelife.com

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.



Attention: Claims Department
 P.O. Box 1650
 Little Rock, Arkansas 72203-1650
 Telephone (800) 370-5856
 Fax (501) 235-8416
 E-mail: claims@usablelife.com

Statement of Claim Cancer and Specified Diseases

For H.O. Use Only
Eff _____
PTD _____
Plan Code _____
Issue Age _____

- Instructions:**
1. Please make sure all questions on Insured's statement are completed in full.
 2. Authorization must be signed and currently dated.
 3. Physician Statement on page 2 must be completed.

INSURED'S STATEMENT

Insured Name (Last, First)	Policy Number (Very Important)		
Home Address (City, State, Zip)	Telephone Numbers		
	Home	Work	
Patient Name (Last, First)	Patient's SSN	Date of Birth	Relation to Insured

Describe symptoms: _____

Date of first treatment: _____

Name and address of first doctor seen: _____

Names and addresses of all doctors and hospitals consulted for **this** condition (Use separate sheet if necessary):

Physician

Address, City, State and ZIP

_____	_____
_____	_____
_____	_____

Have you ever had this or similar condition before? Yes No

If yes, give particulars: Date: _____

Describe: _____

Names and addresses of all doctors seen for any condition in the past five years (Use separate sheet if necessary):

Physician

Address, City, State and Zip

Condition

_____	_____	_____
_____	_____	_____

Authorization to Obtain Information

I hereby authorize any physician or practitioner of the healing arts who has examined or treated me, and all hospitals, clinics or medically related facilities, insurance companies, health maintenance organizations, Medical Information Bureau, government entity (federal, state or local) or other organization, institution or person, that has any information, records or knowledge of me or my health, past or present, to furnish such information to USABLE Life (or its representatives) and to permit them to examine and copy such information. I understand that USABLE Life may disclose the information to the Medical Information Bureau, or reinsurers, or agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claims processing with the company.

A copy of this authorization, or the original, shall be valid for the duration of the claim from the date signed. I acknowledge that I have a right to a copy of this authorization upon request.

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date: _____ **Signature of Patient:** _____

(Parent/Guardian if Minor)

**Please have your Attending Physician complete page 2
 and attach itemized copies of your bills.**

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

ATTENDING PHYSICIAN'S STATEMENT

Please answer all questions and attach itemized bill for all services to date.

Diagnosis and concurrent conditions (Include ICD Code)

Date symptoms first appeared

Date patient first consulted you

If hospitalized, date _____

Inpatient

Outpatient

Hospital Name _____

City, State _____

Have you treated this patient for other conditions?

Yes

No

If yes, give dates and describe _____

Has patient ever had same or similar condition? No

Yes, Date _____

Was patient referred to you?

Yes

No

If yes, name and address of referring doctor _____

Physician's Signature

Date

Physician's Name

Degree

Address

Telephone

City

State

Zip

Fax