**CONTINENTAL AMERICAN INSURANCE COMPANY**
Post Office Box 427• Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970


# CRITICAL ILLNESS HEALTH SCREENING FORM

**Failure to complete all sections may result in a delay in processing this claim.**
**Please review your policy for specific benefits covered under your plan.**

- ✓ **Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.**
- ✓ **If this claim is for an individual covered by Medicaid or a state variation of 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 sign the attached HIPAA Form and return it with the completed claim form.**

☐ **Please check this box if you are filing for a wellness benefit under multiple coverages.**

## AUTHORIZATION

**Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.**

I have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information of me, to give to Continental American Insurance Company or its legal representative, any and all such information. This information is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug or alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. I UNDERSTAND the information obtained by use of the Authorization will be used by Continental American Insurance Company to determine eligibility for benefits under an existing certificate. Any information obtained will not be released by Continental American Insurance Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I AGREE that this Authorization shall be valid for the duration of my claim.

Policyholder's Signature: _____ Date: _____ Patient's Signature: _____ Date: _____

## POLICYHOLDER/PATIENT'S INFORMATION

| POLICYHOLDER'S NAME | POLICY NO. | SOCIAL SECURITY NO. | DATE OF BIRTH | SEX |
|---|---|---|---|---|
| | | | | |

| POLICYHOLDER'S ADDRESS | POLICYHOLDER'S TELEPHONE NO. |
|---|---|
| | |

| PATIENT'S NAME | RELATIONSHIP TO THE POLICYHOLDER | PATIENT'S DATE OF BIRTH | EMPLOYER NAME |
|---|---|---|---|
| | | | |

## HEALTH SCREENING INFORMATION

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:

| | | |
|---|---|---|
| ☐ STRESS TEST ON A BICYCLE OR TREADMILL | ☐ FASTING BLOOD GLUCOSE TEST | ☐ MAMMOGRAPHY (date)_____ |
| ☐ SERUM CHOLESTEROL TEST (HDL AND LDL) | ☐ BONE MARROW TESTING | ☐ BLOOD TEST FOR TRIGLYCERIDES |
| ☐ CA 15-3 (BLOOD TEST FOR BREAST CANCER) | ☐ CA 125 (BLOOD TEST FOR OVARIAN CANCER) | ☐ BREAST ULTRASOUND |
| ☐ CHEST X-RAY | ☐ COLONOSCOPY | ☐ CEA (BLOOD TEST FOR COLON CANCER) |
| ☐ HEMOCULT STOOL ANALYSIS | ☐ THERMOGRAPHY | ☐ FLEXIBLE SIGMOIDOSCOPY |
| ☐ PSA (BLOOD TEST FOR PROSTATE CANCER) | ☐ SERUM PROTEIN ELECTROPHORESIS (MYELOMA) | ☐ PAP SMEAR (date)_____ |
| | | ☐ OTHER |

DATE THE HEALTH SCREENING TEST WAS PERFORMED (treatment date MUST be provided _____

## Physician Information

| Name | Phone Number | |
|---|---|---|
| Street Address | | |
| City | State | Zip |

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INSURED_____ POLICY NUMBER_____

## AUTHORIZATION TO OBTAIN INFORMATION
## CONTINENTAL AMERICAN INSURANCE COMPANY

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

**Disclosure of Health Information**

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, or any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or claim for benefits. Some information 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. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC 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 revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____ _____
(Printed Name of Individual Subject to Disclosure) (Date of Birth)

_____ _____
(Signature) (Date Signed)

If applicable, I signed on behalf of the insured as _____.
(Indicate relationship, legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.)

_____
(Printed Name of Legal Representative)

_____ _____
(Signature of Legal Representative) (Date Signed)