



Group Insurance Program
P.O. Box 9060
Phoenix, AZ 85068-9060

STATEMENT OF CLAIM - HOSPITAL INDEMNITY OR CANCER INSURANCE

Name of Member		Social Security Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Birth
Address		City	State	Zip Code	Is this a New Address? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Patient		Social Security Number	Date of Birth	Phone Number ()	
Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other			Is Patient a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, name of School: _____		
Name of Association (if applicable)		Policy Number		Certificate Number	
Nature of illness or accident - describe (if accident provide accident report or supporting documents)					Date of Accident
Have You Claimed Benefits for this Condition Previously? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when _____					

<u>Give Name and Address Of Any Physicians Who Were Consulted For This Condition</u>	
Name	Address
Name	Address

Warning and Notice: Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines, and/or imprisonment.

California: For your protection, California law requires the following 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: 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 with the Department of Regulatory Agencies.

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.

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.

Authorization: I authorize any doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient, employee or deceased, including financial institutions, to give Monumental Life Insurance Company or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs. A photocopy of this form is as valid as the original. This form will be in force for one year from the date shown below. I may revoke it at any time for information not then obtained by writing to Monumental Life Insurance Company. I certify that the foregoing statements and answers on this form are complete and true to the best of my knowledge.

Signature of Member	Spouse's Signature (if Patient)	Date
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Instructions for filing claims

- Send this **fully** completed claim form to:
Group Insurance Program
P.O. Box 9060
Phoenix, AZ 85068-9060
- Attach all UB92 hospital bills, HCFA1500 physicians bills, physicians superbills (these are standard billing statements used by your providers of service) and any other appropriate medical bills. For HMO or Medicare insureds, please submit verification of confinement from the Hospital if a UB92 hospital bill is not available. All bills must include a diagnosis from your provider of service.
For **Cancer** claims include a pathology report verifying malignancy with all initial submissions.
- If you have any questions call us at **1-800-854-8301**

[AGIA Form# 09443]

Insured or Authorized Representative: Sign this form and return with the claim form to:

**Group Insurance Program
P.O. Box 9060
Phoenix, AZ 85068-9060**

Please keep a copy of this form for your records.

AUTHORIZATION FOR USES AND DISCLOSURES OF MEDICAL INFORMATION

To: Monumental Life Insurance Company ("Insurer")

I hereby give Insurer permission to obtain, use and/or disclose the below Insured's personal health information as follows:

- This authorization was prepared at the request of Insurer for the purpose of evaluating contestability and/or eligibility for benefits.
- The information that is the subject of this authorization and which will be used or disclosed as set forth below includes the release of **all medical records** (except psychotherapy notes), including, but not limited to, those containing medical history, diagnoses, symptoms, treatments, prescription drug information alcohol or drug or tobacco use or abuse or information regarding communicable or infectious conditions, such as AIDS.
- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose the Insured's personal health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical record retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
- I understand that if the person or entity that gives or receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Insurer in reliance on this authorization, by sending a written revocation to: TPA Name, Street Address, City, State Zipcode.
- I understand that I am not required to sign this authorization form and that Insurer will not condition the provision of payment of benefits on the signing of this authorization, except that Insurer may condition evaluating contestability or insurance coverage eligibility for benefits on provision of this authorization if the authorization sought is for insurance coverage contestability evaluation or insurance coverage eligibility relating to the Insured. This authorization will expire 24 months from the date this authorization is signed.

Insured's Name (Print)

Insured's Date of Birth

Authorized Representative's Name (Print)

Relationship to Insured

Signature of Insured or Authorized Representative

Date