



for what happens next®

Division of The Paul Revere Life Insurance Company

Claim Form and Instructions

(Fax to: Claims 1-800-880-9325)

From: _____

Fax Number: _____

Date: _____

Number of pages: _____

Your disability claim must be filed within 12 months of your date of loss.

What can I do to avoid delays?

Missing information is one of the major causes of delay in processing. Please be sure you:

- Sign and return the enclosed Authorization and the Certification on page 3 to avoid delay.
- Complete the sections that apply to your specific claim.
- Enclose the information requested.
- Advise your doctor we may be contacting him/her if additional information is needed.
- Enclose copies of all bills connected with your claim, if applicable.
- Review service options to facilitate your claim.

When should I expect a reply?

We will call you to advise when your claim information is in processing. Mail time is a large contributor to the time it takes for our response to reach you. Mail may take up to four or five days each way.

To avoid mail delays:

- If you fax your claim, please do not mail the original document but keep it for your records.
- Fax your claim to us at 1-800-880-9325. Please allow **48 hours** for our automated service center to be updated with information confirming receipt of your fax, or....
- Have your payment returned by **overnight delivery** by initialing the Service Release below. A \$15.00 charge for this service will be deducted from your claim payment. This cost is subject to rate increases by overnight carriers. Your check will be sent overnight the next business day to the address on this form. If it is returned due to an incorrect address, we will re-send by regular mail. We will only overnight payments over \$100.00. A street address is required. Your check will be delivered Monday through Friday; however, the time is not guaranteed.

OPTIONAL SERVICE RELEASE AGREEMENT-Please initial below as indicated.

- _____
(initial) I authorize The Paul Revere Life Insurance Company to facilitate processing this claim by discussing its details with a local sales representative if he/she is inquiring on my behalf.
- _____
(initial) I authorize The Paul Revere Life Insurance Company to facilitate processing this claim by discussing its details with my plan administrator if he/she is inquiring on my behalf.
- _____
(initial) I authorize The Paul Revere Life Insurance Company to communicate information (other than medical) or the status of this claim through electronic messaging at my home phone number as indicated on this form. I understand messages will be left with any person answering the phone or on my voicemail/ answering machine.
- _____
(initial) Yes, please deduct the \$15 fee (cost subject to rate increases) to overnight any applicable benefits from my claim payment for this claim. I understand this fee will be deducted for future payments for this loss and payments overnighted as well unless I notify the company in writing to use normal mail service. I understand payments under \$100.00 will be sent by regular mail.

Authorized service options are valid for two (2) years from the date executed or for the duration of my claim, whichever is earlier. I may revoke these options at any time by notifying The Paul Revere Life Insurance Company in writing, but the revocation will not have any affect on any action taken before receipt of the revocation. I may request access to this information. I am not required to agree to any of these options to obtain my benefits. The information disclosed may be shared by us.

CLAIMANT NAME: **X** _____ SOCIAL SECURITY NUMBER: _____

- If you are filing a claim for a sickness or health condition occurring within the first 6 to 24 months of your policy/certificate (based on policy requirements), we need to confirm if the condition is pre-existing. Please notify your doctor we will be contacting him/her and provide him/her with a copy of your authorization to release information to us. If we must write to your doctor, please expect a delay in the processing of this claim.
- Benefits are payable to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called an assignment. If you wish to assign your benefits, please attach a signed written request.
- 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.

If you wish to file a Wellness/Cancer Screening claim for a test performed within the past 12 months, you need the name and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number. You may:

- FILE BY PHONE! Call 1-800-325-4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week, or
- SUBMIT ON THE INTERNET using the Wellness Claim Form at www.colonial-paulrevere.com, or
- Write your name, address, Social Security number and/or policy/certificate number on your bill and indicate "Wellness Test." FAX this to us at 1-800-880-9325 or MAIL to PO Box 100195, Columbia SC 29202.

If your Wellness/Cancer Screening test was more than one year ago, you must fax or mail us a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.

Please note: If your cancer policy includes a second part to the screening benefit, bills for tests covered and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

Mail to: Colonial Supplemental Insurance
Processing Center
P.O. Box 100195
Columbia SC 29202-3195

Fax to: 1-800-880-9325

If you fax your claim, please
keep the original for your files.

It's easy, really... This is a multi-purpose form. Complete the general information section on this page. Then, you only need to have those sections completed that apply to your individual situation and coverage. Information does not have to be written on this form, as long as any documentation you send has the information needed to process your claim.

Please **check** the type claim you are filing below:

- Accidental Injury- Section A requests specific information from you about the circumstances of your injury.
- Routine Pregnancy- Have your doctor complete Section B if you are filing for benefits for normal post-delivery disability.
- Cancer Policy- Section C provides instructions for claiming benefits under your cancer policy.
- Hospital Confinement, Intensive Care or Outpatient Surgery- Have your doctor complete Section D and send copies of your hospital or outpatient surgery bills.
- Total Disability- Section E contains parts for both your employer and doctor to complete.

If you are filing a claim for any other type claim, please call us at 1-800-325-4368. We will assist you with the information and forms needed.

This claim is for: ___ Self ___ Spouse ___ Dependent: if over 18, name of school _____

Has your address changed since we last heard from you? ___ YES ___ NO

Name of Policyholder/Employee _____ Name of Patient (if not self) _____

Social Security Number: _____ Social Security Number: _____

Date of Birth:(mm/dd/yyyy) _____ Date of Birth: (mm/dd/yyyy) _____

Address _____
Street (Apt. #) _____ City _____ State _____ Zip _____

Home Phone Number: (_____) _____ Work Phone Number: (_____) _____

Fax Number: (_____) _____ Email Address: _____

Please print INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL

Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).

Full name of treating doctor _____

Mailing Address _____ City _____ State _____ Zip Code _____

(_____) _____ (_____) _____

Phone number _____ Fax number _____

Full name of primary doctor _____

Mailing Address _____ City _____ State _____ Zip Code _____

(_____) _____ (_____) _____

Phone number _____ Fax number _____

Full name of referring doctor/hospital _____

Mailing Address _____ City _____ State _____ Zip Code _____

(_____) _____ (_____) _____

Phone number _____ Fax number _____

CERTIFICATION

Policyholder/Employee's Name _____ Social Security # _____

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.

X ____ / ____ / ____
Date (mm/dd/yyyy)

X _____
PATIENT SIGNATURE

X _____
POLICYHOLDER/EMPLOYEE SIGNATURE

CLAIMANT NAME: _____ SOCIAL SECURITY NUMBER: _____

A. ACCIDENTAL INJURY- please complete and attach itemized copies of any related bills including doctor, emergency room, and hospital. Bills should include diagnosis information (from your medical provider).

Date of accident(mm/dd/yyyy): ____/____/____ Time of accident: _____ am/ pm (circle one)

Tell us how your accident happened: (If you need more space, you may attach on a separate piece of paper.)

Were you at work, working for wage or profit, at the time of your accident? _____ Yes _____ No

Have you ever had a similar injury? _____ If so, please tell us when (mm/dd/yyyy): _____

If you are claiming disability, please have your employer and doctor complete SECTION E.

B. ROUTINE PREGNANCY (6 weeks for vaginal delivery, or 8 weeks for c-section less the elimination period)

Date of Delivery: (mm/dd/yyyy) ____/____/____ First Date of Treatment(mm/dd/yyyy): ____/____/____

Type delivery: Vaginal/ C-Section (circle one) Dates of Hospital Confinement (mm/dd/yyyy): ____/____/____ - ____/____/____

Name of Hospital: _____ Hospital Phone Number: (____) _____

Doctor's Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

_____ Tax Identification Number: _____

Treating Doctor's Signature: _____ Date(mm/dd/yyyy): _____

Referring Physician: _____ Phone number: (____) _____

Mailing address

If disabled due to complications of pregnancy, before or after delivery, complete Section E.

C. CANCER

If you do not have a cancer policy, please complete the sections that apply to your coverage. To file for benefits under a cancer policy, please complete page 3 and check cancer at the top of the page:

- For Internal Cancer- Attach a copy of the pathology report from your initial diagnosis
- Attach copies of itemized statements for all medical expenses incurred relating to the diagnosis and treatment of your malignancy. Please clearly write your name and social security number on each bill.
- For Skin Cancer- Attach a copy of your pathology report for each date of service a lesion was biopsied and/or removed.
- Transportation and Lodging- Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.
- If you are claiming disability, please have your employer and doctor complete SECTION E.

CLAIMANT NAME: _____ SOCIAL SECURITY NUMBER: _____

D. HOSPITAL CONFINEMENT, INTENSIVE CARE OR OUTPATIENT SURGERY BENEFITS. Please send an itemized copy of your hospital bill which includes the diagnosis, admission and discharge dates. Have your doctor complete this section if your bills do not include diagnosis information.

Diagnosis/ICD-9 Code: _____

Dates of Inpatient Hospital Confinement: From: ____/____/____ To: ____/____/____

Dates of Confinement in Intensive Care, including Coronary Care Unit: From ____/____/____ To: ____/____/____

Hospital: _____ Phone Number (____) _____

Hospital Address: _____

Date of Surgery (mm/dd/yyyy): ____/____/____ Inpatient/Outpatient (circle one)

Procedure/procedure code: _____

Date of office visit following confinement or outpatient surgery (mm/dd/yyyy): ____/____/____ - ____/____/____

Signature of doctor: _____ Date (mm/dd/yyyy): ____/____/____

Name of doctor: _____ Phone: (____) _____

Fax number: (____) _____

Address _____ Tax ID or SSN: _____

NOTE: Please make a copy of the patient's signed authorization to release information for your records.

If you are claiming disability, please have your employer and doctor complete SECTION E.

E. DISABILITY BENEFITS:

To be completed and signed by your EMPLOYER:

Name of Employer: _____ Phone Number: (____) _____

Fax Number:(____) _____

Employee's Job Title: _____

Dates this employee has been unable to work:

From: ____/____/____ am/pm To: ____/____/____ am/pm From: ____/____/____ am/pm To: ____/____/____ am/pm

Date employee returned to main or principal duties: ____/____/____ Date employee returned to light duty: ____/____/____

Monthly salary \$ _____

Did the accident occur while working for wage/profit? ____ yes ____ no

Name and address of Workers Compensation carrier, if applicable:

Signed: _____ Title: _____ Date (mm/dd/yyyy): ____/____/____

(To be signed by your employer)

CLAIMANT NAME: _____ SOCIAL SECURITY NUMBER: _____

To be completed and signed by the DOCTOR treating you for this disability: _____

Diagnosis/ primary disabling condition/ ICD9 Code(s): _____

Is this condition the result of an accidental injury? ____ Yes ____ No If yes, please provide us with the date and description.

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment:

Dates of Inpatient Hospital Confinement: From: ____/____/____ To: ____/____/____

Hospital: _____
Name
Address

List any surgeries performed and submit a copy of the operative report. _____

How soon do you expect significant improvement in the patient's medical condition? _____ # weeks/months (circle one)

If due to complications of pregnancy prior to delivery, what is EDC? ____/____/____

Dates unable to work: full duty From: ____/____/____ To: ____/____/____

Dates unable to work: partial duty From: ____/____/____ To: ____/____/____

Anticipated return to work/release date: _____ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

Dates of treatment (mm/dd/yyyy): _____

Is this patient considered to be house confined or unable to perform 2 or more activities of daily living? (If not working at time of accident or when disability begins.) Yes/ No (circle one) If so, date (mm/dd/yyyy) from: _____ to _____ (This information will be used in accordance with state regulations and policy provisions.)

Restrictions/Limitations _____

Secondary conditions contributing to this disability: _____

Would the patient be disabled without regards to these secondary conditions? ____ yes ____ no

Is this patient permanently disabled? ____ Yes ____ No If yes, what is recommended frequency of treatment? _____

Does this patient have permanent restrictions/limitations? If so, list: _____

Signature of doctor: _____ Date (mm/dd/yyyy): ____/____/____ Patient #: _____

Name of doctor: _____ Phone: _____ Fax: _____

Address: _____

Email address: _____ Tax ID or SSN: _____

Full name of referring doctor _____

Mailing Address _____ City _____ State _____ Zip Code _____

(_____) (_____) _____
Phone number Fax number

NOTE: Please make a copy of the patient's signed authorization to release information for your records.