Claim Filing Kit:
Critical Illness and Cancer and Heart/Stroke

Allstate Health Solutions requires all records related to the illness be submitted with this claim form. Claims will not be eligible for review until all required documents are received. It is your responsibility to provide the following to us:

- **Completed claim form.** Complete the attached claim form, in its entirety.
    - **HIPAA Authorization.**
      Must be signed by patient or, if a minor, a legal guardian.
    - **Physician Statement.**
      Must be completed and signed by your treating physician.
- **Medical notes:**
    - **Cancer Claims.** A pathology report showing the positive diagnosis of cancer and the date of diagnosis.
    - **Critical Illness and Heart/Stroke Claims.** All medical records associated with the illness, from the provider including a print out from your pharmacy with all current medications.
- **All required documentation should be submitted to:**

Mail: Allstate Health Solutions
P.O. Box 3252
Milwaukee, WI 53201-3252
Fax: 317-284-7281
Email: NationalGeneral.customerservice@keybenefit.com

Once we receive the required documentation we will begin the claim review process in accordance to the provisions of the policy. Completing and submitting the requested documentation is not a guarantee of benefits. Always refer to your policy documents for the complete listing of benefits, limitations and exclusions

If you have any questions about this kit, please call (855) 212-5014.

Please print clearly

Critical Illness and Cancer and Heart/Stroke Claim Form

General Information — *to be completed by Policy Owner.*

Critical Illness and/or Cancer and Heart/Stroke Policy Number(s):

____

Policy Owner Full Name: ____

Street Address: ____

City: ______________________ State: ____________________ Zip: ____________

Phone Number: ______________________ Employer: ________________________

Occupation: ____

Nature of Illness: ____

Statement of Loss — *to be completed by insured, or Claimant, if other than insured.*

Claimant Full Name: ____

Date of Birth: ______________________ (MM/DD/YY)

Relationship to Policy Holder *(circle one)* : Self Spouse Child Other

If other, please define: ____

Describe Sickness:

____

____

____

____

Primary Care Physician

Name: ____

Address: ____

Phone Number: ______________________________

List all providers, including pharmacies, who have treated you for the past 5 years (Include name, address & telephone number): ______________________________________

____

____

____

Date you first consulted this physician for this condition: ____________________ (MM/DD/YY)

Have you ever had this condition before? Yes ______ No _______

If yes, when? _____ / _____ / ______ (MM/DD/YY)

*You must file with all other responsible parties first. This policy provides Excess benefits only. in the absence of other insurance, charges may be subjext to a higher deductible. please refer to the Scope of Benefits section of your Certificate of Coverage.

Claimant name:
Claimant date of birth:
Provider/Facility (completed by Insurer/Requester at time of request): ______________________________

Authorization for the Release and Disclosure of Confidential Medical Information

The records and information obtained pursuant to this Authorization will be disclosed to National Health Insurance Company, Integon National Insurance Company, and/or Integon Indemnity Corporation (collectively "Allstate Health Solutions"), any consumer reporting agency authorized by Allstate Health Solutions, its legal representative(s), its third party administrator(s) (including Key Benefit Administrators), or any medical records retrieval service Allstate Health Solutions may engage, including, but not limited to, American Retrieval Company, and its agents.

I, or my legal representative, do hereby authorize any and all of my medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records' custodians, or any other health care provider to release any and all records and information, including diagnosis, testing, treatment and prognosis of my physical or mental condition, within their possession, custody or control regarding me in accordance with this Authorization. Such records and information to be released may include, but not to be limited to the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, Human Immunodeficiency Virus (HIV) testing and treatment, Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Disease (STD) testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's. I understand that the purpose of this disclosure is to evaluate the eligibility of benefits or my claims for payment with respect to my insurance coverage with Allstate Health Solutions.

This authorization will remain in effect for a maximum of one year from the date of my signature below.

I understand that I may revoke this authorization at any time by sending a written notification via U.S. Mail to Attention: Privacy Department, P.O. Box 2070, Milwaukee, WI 53201-2070 or fax to 317-284-7281. I understand that a revocation of this authorization is not effective if Allstate Health Solutions has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the coverage itself. This revocation will be effective for future uses and disclosures only and will not apply to information that has already been used or disclosed in reliance on this authorization. Once health information about me has been disclosed by Allstate Health Solutions to a third party, the health information may be subject to redisclosure by the recipient and no longer be protected by federal privacy laws. If I choose not to sign this authorization or if I later revoke it, I understand that Allstate Health Solutions may not be able to process my application for coverage; if coverage has been issued, Allstate Health Solutions may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services. Your provider may require you to complete an additional authorization form. If asked to complete this authorization, your prompt response will help expedite the process.

Allstate Health Solutions is a marketing name for products underwritten by National Health Insurance Company, Integon National Insurance Company, Integon Indemnity Corporation.

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Claims submitted on dependents 18 and older require an authorization signed by the dependent.

______________________________	______________________________
Signature of claimant/legal guardian	Relationship of legal guardian
Print name of claimant/legal guardian	Date signed (mm/dd/yyyy)

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

______________________________	______________________________
Signature of legal representative	Relationship
Print name of legal representative	Date signed (mm/dd/yyyy)

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Please print clearly

Physician Statement

The treating physician must complete this section and submit the completed form and all supporting documentation of the diagnosis to Allstate Health Solutions by either:

Fax: 317-284-7281 or Email: NationalGeneral.customerservice@keybenefit.com

Patient's Information

Last Name:____________________________ First name:________________________ MI:_____

Date of Birth: __________________ (MM/DD/YY) Gender: Male ☐ Female ☐

Date patient first consulted you for this condition: ___________________________ (MM/DD/YY)

Date patient was first diagnosed with this condition: _________________________ (MM/DD/YY)

If hospitalized, provide the date range. From date:______________ To date:________________

Applicable diagnosis codes: ____

Applicable procedure (CPT) codes: ____

Name and Address of Facility where services were rendered: _______________________________

____

Have you previously treated this patient? ☐ Yes ☐ No

If "Yes", provide illness and dates treated: _______________________________________

______________________ From date:________________ To date:__________________

Has this patient ever had the same or similar conditions? ☐ Yes ☐ No

If "Yes", please describe and provide dates: ______________________________________

______________________ From date:________________ To date:__________________

Does the patient suffer from any chronic illness? ☐ Yes ☐ No

If "Yes", please identify: ____

Does the patient take prescription medication regularly? ☐ Yes ☐ No

If "Yes", please identify: ____

Has any other physician ever treated the patient for this condition? ☐ Yes ☐ No

Name and Address of physician who previously treated this patient: ___________________

____

Name, Address and Phone Number of referring physician: ___________________________________

____

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Physician's Name — printed: ____

Address — including city, state and zip code: ______________________________________

____

Phone Number: ____________________________ *Fax Number:* ___________________________

Signature — including degrees and credentials

____ *Date:* _______________

State Specific Fraud Statements:

The law in **ALASKA** states: “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.”

For your protection the law in **ARIZONA** states: “Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.”

The law in **ARKANSAS** states: “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.

For your protection the law in **CALIFORNIA** states: “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.”

The law in **COLORADO** states: “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 within the department of regulatory agencies.

The law in **DELAWARE** states: “Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.”

The law in the **DISTRICT OF COLUMBIA** states: “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.”

The law in **FLORIDA** states: “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.”

The law in **IDAHO** states: “Any person who knowingly, and with intent to defraud or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading, information is guilty of a felony.”

The law in **INDIANA** states: “A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.”

The law in **KENTUCKY** states: “Any person who knowingly and with intent to defraud any insurance company or other person files a 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.”

The law in **LOUISIANA** states: “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.”

The law in **MAINE** states: “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

The law in **MINNESOTA** states: “A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.”

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HEALTH SOLUTIONS

State Specific Fraud Statements:

The law in **NEW HAMPSHIRE** states: “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.”

The law in **NEW JERSEY** states: “Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.”

The law in **NEW MEXICO** states: “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 civil fines and criminal penalties.”

The law in **NEW YORK** states: “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.”

The law in **OHIO** states: “Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.”

The law in **OKLAHOMA** states “WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.”

The law in **PENNSYLVANIA** states: “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 subjects such person to criminal and civil penalties.”

The law in **RHODE ISLAND** states: “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.”

The law in **TENNESSEE** states: “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

The law in **TEXAS** states: “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.”

The law in **VIRGINIA** states: “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

The law in **WASHINGTON** states: “It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.”

The law in **WEST VIRGINIA** states: “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.”

Allstate Health Solutions is a marketing name for products underwritten by National Health Insurance Company, Integon National Insurance Company, Integon Indemnity Corporation and American Heritage Life Insurance Company.

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