CANCER & SPECIFIED DISEASE CLAIM FORM

Instructions

Cancer Claim

Please complete the Policyholder/Claimant Information section below. It is imperative that you attach a copy of the Pathology report used in the diagnosis of cancer. If you are filing for benefits under a lump-sum cancer policy, which provides a pre-determined amount upon the positive diagnosis of internal cancer, you will also need to attach a certified copy of your birth certificate. If you are filing for benefits under a cancer expense plan, which provides benefits for the actual medical expenses incurred, in addition to the pathology report, please attach a copy of medical bills associated with the treatment of cancer. Please read the authorization section and sign in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. Failure to sign the authorization will delay the processing of your claim.

Cancer Screening Claim

If you are filing for the Cancer Screening benefit, complete the first three lines of the Policyholder/Claimant Information section and the Cancer Screening Information section. Attach documentation indicating the type of test performed, the date the test was performed, and the charges incurred.

Send all claims to:

Continental American Insurance Company
Cancer Claims Processing Unit
Post Office Box 427
Columbia, South Carolina 29202
(800) 433-3036

POLICYHOLDER/CLAIMANT INFORMATION

POLICYHOLDER'S NAME	POLICY/CERTIFICATE NO.	DATE OF BIRTH	SEX

POLICYHOLDER'S ADDRESS	POLICYHOLDER'S TELEPHONE NO.

CLAIMANT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	CLAIMANT'S DATE OF BIRTH	CLAIMANT'S DATE OF DEATH (IF APPLICABLE)

WHAT DATE WAS THE CANCER FIRST DIAGNOSED BY A PATHOLOGIST? (ATTACH A COPY OF THE PATHOLOGY REPORT)	WHEN DID SYMPTOM FIRST APPEAR?	HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION: ☐ YES ☐ NO

LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIANS FOR THE CANCER (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)

IF THE CANCER REQUIRED HOSPITALIZATION, PROVIDE THE NAME AND ADDRESS OF THE TREATING FACILITY (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)

CANCER SCREENING INFORMATION

WHICH CANCER SCREENING TEST DID YOU HAVE PERFORMED?

☐ COLONOSCOPY	☐ FLEXIBLE SIGMOIDOSCOPY	☐ CHEST X-RAY
☐ CEA (BLOOD TEST FOR COLON CANCER)	☐ CA 125 (BLOOD TEST FOR OVARIAN CANCER)	☐ PSA (BLOOD TEST FOR PROSTATE CANCER)
☐ CA 15-3 (BLOOD TEST FOR BREAST CANCER)	☐ THERMOGRAPHY	☐ BONE MARROW TESTING
☐ SERUM PROTEIN ELECTROPHORESIS (MYELOMA)	☐ PAP SMEAR	☐ HEMOCULT STOOL ANALYSIS
☐ MAMMOGRAPHY	☐ BREAST ULTRASOUND	☐ OTHER

DATE THE CANCER SCREENING TEST WAS PERFORMED:

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

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 policy. 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: Claimant's Signature: Date: