GROUP VOLUNTARY CRITICAL ILLNESS POLICY AND OPTIONAL RIDER CLAIM FORM

If you have any questions regarding benefits available, or how to file your claim, or if you would like to appeal any determination, please contact our Customer Service Center at 1-855-900-4777, 8:00 A.M. to 5:00 PM Central Standard Time or email us at claims@bbadmin.com

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

Mail, fax or email your claim to: **Bay Bridge Administrators, LLC.**
P.O. Box 161690
Austin, TX 78716
Fax: 512-275-9350 **Email:** claims@bbadmin.com
This form can be found on our website at www.baybridgeadministrators.com

CERTIFICATE HOLDER / CLAIMANT INFORMATION:

CERTIFICATE NUMBER(S):_____

CERTIFICATE HOLDER: First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ ☐ Male ☐ Female

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ ☐ **Check here if address is new**

Phone #: _____ E-mail: _____

Employer: _____ Occupation: _____

CLAIMANT: (if different) First Name: _____ MI: ___ Last Name: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

INSTRUCTIONS FOR REQUESTING AVAILABLE BENEFITS:

- The following are benefits available under the Critical Illness Certificate and the Optional Riders (if purchased).
- Please select the Benefits you believe may be due based upon the Covered Person's Critical Illness and attach the required documentation.
- The required documentation needs to include the **patient's name, diagnosis and dates of service**.
- If you are asked to provide a bill as required documentation, please ask your provider for: **UB04, HCFA1500, or an itemized bill.**
- We also require you to sign and submit the Authorization to Release Information to Wellfleet Form.
- You will ne notified if additional information is needed.
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

Benefits may vary by product and/or state. In addition, you may not have purchased the Optional Rider(s) available. Please refer to your certificate and rider(s) for specific benefits available to you.

☐ **NEW CLAIM or ☐ CONTINUED CLAIM**

CRITICAL ILLNESS BENEFIT (Please attach the medical record documentation of your condition)

- ☐ **Heart Attack:** Electrocardiographic proof and lab findings of elevated cardiac enzymes. Additional test results that may be required are stress echo, cardiac catherization, PECT or Thallium.
- ☐ **Stroke:** Medical record documentation of permanent neurological deficit for 30 days or more (CAT scan, MRI).
- ☐ **Coronary Artery Bypass:** Provide medical record that physician recommends surgery.
- ☐ **Major Organ Failure:** Provide medical record that physician has placed person on UNOS. Does not include transplants involving mechanical or non-human organs.
- ☐ **End-Stage Renal Failure:** Medical records documenting failure in both kidneys and proof of dialysis at regular weekly intervals.

CANCER BENEFIT (Please attach the medical record documentation of your condition)

- ☐ **Invasive Cancer:** Provide pathology report supporting histological evidence of malignancy.
- ☐ **Cancer in Situ:** Provide pathology report.
- ☐ **Skin Cancer:** Provide pathology report showing abnormal growth of skin cells.

ENHANCED PACKAGE

- ☐ **Sudden Cardiac Death:** Provide certified death certificate (must be an original).
- ☐ **Angioplasty:** Provide medical documentation that physician recommends surgery.
- ☐ **Benign Brain Tumor:** Provide medical documentation
- ☐ **Coma:** Provide medical documentation that profound unconsciousness was for at least 14 days
- ☐ **Hearing Loss:** Provide medical documentation that hearing loss is not due to congenital birth defect, developmental delays or can be corrected by any procedure, aid or device.
- ☐ **Loss of Sight:** Provide medical documentation is total and irrecoverable.
- ☐ **Paralysis:** Provide medical documentation and Attending Physician's Statement showing spinal cord injury resulting in paraplegia or quadriplegia.
- ☐ **Type 1 Diabetes:** Provide medical documentation showing disease.
- ☐ **Occupational HIV:** Provide medical documentation that HIV was caused by accidental needle stick or sharp injury while performing occupational duties and is reported by the covered person.

PROGRESSIVE DISEASE BENEFIT (Not an eligible benefit for children)

- ☐ **Multiple Sclerosis:** Provide medical documentation of disease and must meet specifics listed in the Certificate.
- ☐ **ALS:** Provide medical documentation of disease.
- ☐ **Alzheimer's Disease:** Provide medical documentation of disease.
- ☐ **Addison's Disease:** Provide medical documentation of disease.
- ☐ **Huntington Disease:** Provide medical documentation of disease.
- ☐ **Parkinson's Disease:** Provide medical documentation of disease.

CHILDREN'S ONLY CONDITIONS

- ☐ **Cerebral Palsy:** Provide medical documentation of disease.
- ☐ **Congenital Defect:** Provide medical documentation of disease showing abnormalities in the structure of body parts.
- ☐ **Genetic Disorder:** Provide medical documentation of disorder showing abnormalities in an individual's DNA.
- ☐ **Type 1 Diabetes:** Provide medical documentation showing disease.
- ☐ **Congenital Metabolic Disorder:** Provide medical documentation of disorder.
- ☐ **Multiple Sclerosis:** Provide medical documentation of disease and must meet specifics listed in the Certificate.

OPTIONAL RIDERS (check those that apply)

- ☐ **Wellness Benefit Rider:** Provide bill for Wellness Initiative and Screenings. See Certificate for list of covered tests.
- ☐ **Enhanced Cancer Rider:** Additional benefits when a specified covered disease is covered. Please check all that apply. Medical records or billing notices must be submitted.
  - ☐ Radiation, Chemotherapy or Immunotherapy
  - ☐ Outpatient Surgery Benefit
  - ☐ Hospital Confinement
  - ☐ Durable Goods & Equipment
  - ☐ Extended Care – Facility Benefit
  - ☐ National Cancer Institute Evaluation
  - ☐ Bone Marrow or Stem Cell Transplant
  - ☐ Hospital Confinement
  - ☐ Transportation & Lodging – Lodging Benefit
  - ☐ Transportation & Lodging – Transportation Benefit
  - ☐ Extended Care – Home Health Care Benefit

☐ **Caregiver Rider:** Caregiver means a covered person who provides caregiver functions to a covered person who is either the insured, the covered spouse or the covered child. Provide physician's orders recommending a caregiver and that the caregiver is not able to perform their usual duties of employment due to providing caregiver functions.

CERTIFICATION: Please read and sign below

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete and correctly recorded. **Please also remember to sign and date the attached authorization required to process your claim.**

Signature: _____ Print Name:_____ Date: _____

ATTENDING PHYSCIAN'S STATEMENT

To be completed and signed by the Attending Physician for Illness Only

Patient's Name: _____ DOB: _____

1.) Diagnosis: _____

2.) When did symptoms first appear? Date _____/____/_____
MO / DAY /YR

3.) When did patient first consult you for this condition? Date _____/____/_____
MO / DAY /YR

4.) Has patient ever had same or similar condition? (If "yes", state when and describe.) ☐ Yes ☐ No _____
_____

5.) Describe any other diseases or infirmity affecting present condition. _____

6.) Nature of surgical procedure, if any (describe fully). _____
_____

7.) Date patient last examined by you: _____ Frequency of visits: ☐ weekly ☐ monthly ☐ other _____

8.) If patient is hospitalized, give name and address of hospital.

Hospital: _____ City: _____ State: _____

9.) Date admitted: _____/____/_____ Date discharged: _____/____/_____
MO / DAY /YR MO / DAY /YR

10.) Name and address of referring physician if any.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____

RETURN TO WORK ASSESSMENT

Did you advise the patient to stop work? ☐ Yes ☐ No	If yes, when (mm/dd/yy)?	Have you advised patient to return to work? ☐ Yes ☐ No	If yes, expected return to work date (mm/dd/yy) ☐ Full Time ☐ Part Time

If patient can return to work are there restrictions? (if yes, please describe) ☐ Yes ☐ No

_____

If no, please indicate the restrictions and limitations that prevent the patient from returning to work.

_____

PHYSICIAN VERIFICATION

Signed: _____ Date: _____ Phone: _____

Street Address: _____

City/Town: _____ State: _____ Zip Code: _____

FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.

Alabama. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska. 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.

Arizona. For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia. 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.

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 within the Department of Regulatory Agencies.

Delaware. 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.

District of Columbia. 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.

Florida. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

Indiana. 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.

Kentucky. 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.

Maine. 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.

Maryland. Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota. A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire. 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.

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 Mexico. 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.

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 subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio. Any person who, with intent to defraud or knowing that he 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.

Oklahoma. 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.

Oregon. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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.

Puerto Rico. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Tennessee, Virginia and Washington. 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.

Texas. 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.

WELLFLEET
WORKPLACE

BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"®

AUTHORIZATION FOR RELEASE OF INFORMATION

Instructions

1. Complete all applicable areas of the following form
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign the form.
4. Return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under the disability plan.

RETURN COMPLETED FORMS AND DIRECT CORRESPONDENCE TO:

BAY BRIDGE ADMINISTRATORS, LLC.
P.O. BOX 161690
AUSTIN, TX 78716
(855) 900-4777
FAX: (512) 275-9350
CLAIMS@BBADMIN.COM

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ Please check this box if you or your authorized representative would like to receive a copy of this form.

Claimant Information: (name of Claimant whose information will be released)

Name: _____ (Last, First, Middle)	Date of Birth: _____/___/_____
Other Name Used: _____	Social Security Number: _____-_____-_____

I authorize any licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all of the following information to Wellfleet or to persons or other organizations providing claims management services:

Description of the information to be disclosed: I understand that this Authorization for Release of Information specifically includes my permission to disclose my entire record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records (excluding psychotherapy notes); claims history including but not limited to Prescription Drug Databases, pharmacy benefits management companies, ambulance, insurance companies, medical transcripts, or the MIB; and, alcohol or drug abuse including any data protected by Federal Regulation 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations at the federal, state or local level. I also understand that work and financial information are necessary to process my claim and I give my permission to disclose related records about me including but not limited to employment, compensation, compensation sources, insurance companies, financial institutions, and government entities. By signing below, I consent to the disclosure of such information but only in accordance with the laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

Expiration: Unless revoked as discussed below, This Authorization will be considered valid for a period of twenty-four (24) months from the date this form is signed, or for the duration of the claim for benefits, whichever the shorter.

Right to Revoke: I have the right to revoke this authorization, in writing, at any time by contacting Wellfleet at the address provided on the previous page. I understand that revocation is not effective to the extent that Wellfleet has taken action in reliance on this authorization.

Claimant Rights:

1. I understand that the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may <u>not</u> be redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.

4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

Authorized Representative Information: Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless parent signing for patient under 18.

Name: _____ (Last, First, Middle) Relationship to Claimant: _____	Mailing Address: _____ _____ phone: _____-_____-_____