CANCER 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
Phone: (866) 849-0011 Fax: (866) 849-2970
E-mail: agi-claimsimaging@caicworksite.com

POLICYHOLDER/CLAIMANT INFORMATION

EMPLOYER'S NAME					
POLICYHOLDER'S FIRST NAME	POLICYHOLDER'S LAST NAME	POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX
POLICYHOLDER'S ADDRESS				POLICYHOLDER'S TELEPHONE NO.	
CLAIMANT'S FIRST NAME	CLAIMANT'S LAST 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 hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

Policyholder's Signature: ______________________________ Date: ______________

Claimant's Signature: ______________________________ Date: ______________