PO Box 427 Columbia, SC 29202
Phone (866) 849-0011
Fax (866) 849-2970
agi-claimsimaging@caicworksite.com

WELLNESS AND HEALTH SCREENING CLAIM FORM

Failure to complete all sections may result in delayed processing of this claim.
Review your policy for specific benefits covered under your plan.

AUTHORIZATION

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 practioner, hospital, clinic other medical or medically related facility, insurance company, consumer report 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 for 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 certificate. Any information obtained will not be released by Continental American Insurance Company to any person or organization EXCEPT to re-insuring companies or other person or organization performing business or legal services in connection with any claim, or as may otherwise be lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that this authorization shall be valid for the duration of my claim.

Policyholder's Signature: _____ **Date:** _____ **Claimant's Signature:** _____ **Date:** _____

POLICYHOLDER/PATIENT INFORMATION

EMPLOYER'S NAME				POLICYHOLDERS EMAIL ADDRESS	
POLICYHOLDER'S NAME	POLICY NO		SSN/EMPLOYEE ID	DATE OF BIRTH	GENDER
POLICYHOLDER'S ADDRESS	CITY	STATE	ZIP CODE	POLICYHOLDER'S PHONE NUMBER	
PATIENT'S NAME	RELATIONSHIP TO THE POLICYHOLDER			PATIENT'S DATE OF BIRTH	PATIENT'S GENDER

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you).

HEALTH SCREENING INFORMATION

DATE HEALTH SCREENING TEST WAS PERFORMED: _____

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:

- ☐ Annual Physical
- ☐ Biometric Screening
- ☐ Blood Screening
- ☐ Blood Test for Triglycerides
- ☐ Bone Marrow Testing
- ☐ Breast Ultrasound
- ☐ CA 125
- ☐ CA 15-3
- ☐ CEA
- ☐ Chest X-Ray
- ☐ Colonoscopy
- ☐ DNA Stool Analysis
- ☐ Eye Examinations
- ☐ Fasting Blood Glucose
- ☐ Flexible Sigmoidoscopy
- ☐ Hemoccult Stool Analysis
- ☐ HIV (Human Immunodeficiency)
- ☐ HPV (Human Papillomavirus)
- ☐ HSN Strains
- ☐ Human Coronavirus Testing
- ☐ Immunizations
- ☐ Mammograms
- ☐ Non-Diagnostic Vascular Screening
- ☐ Pap Smears
- ☐ PSA Test
- ☐ Serum Cholesterol Test
- ☐ Serum Protein
- ☐ Skin Cancer Screening
- ☐ Spinal CT Screening
- ☐ Stress Test on Bicycle or Treadmill
- ☐ Thermography
- ☐ Ultrasounds
- ☐ Urinalysis

PHYSICIAN INFORMATION

NAME		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

The Wellness and Health Screening Claim Form will be used to review for wellness benefits on all covered plans.