



# 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: csc@caicworksite.com**

POLICYHOLDER/CLAIMANT INFORMATION					
EMPLOYER'S NAME					
POLICYHOLDER'S NAME		POLICY/CERTIFICATE NO.	SOCIAL SECURITY 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: <input type="checkbox"/> YES <input type="checkbox"/> 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:					
<input type="checkbox"/> COLONOSCOPY	<input type="checkbox"/> FLEXIBLE SIGMOIDOSCOPY	<input type="checkbox"/> CHEST X-RAY			
<input type="checkbox"/> CEA (BLOOD TEST FOR COLON CANCER)	<input type="checkbox"/> CA 125 (BLOOD TEST FOR OVARIAN CANCER)	<input type="checkbox"/> PSA (BLOOD TEST FOR PROSTATE CANCER)			
<input type="checkbox"/> CA 15-3 (BLOOD TEST FOR BREAST CANCER)	<input type="checkbox"/> THERMOGRAPHY	<input type="checkbox"/> BONE MARROW TESTING			
<input type="checkbox"/> SERUM PROTEIN ELECTROPHORESIS (MYELOMA)	<input type="checkbox"/> PAP SMEAR	<input type="checkbox"/> HEMOCULT STOOL ANALYSIS			
<input type="checkbox"/> MAMMOGRAPHY	<input type="checkbox"/> BREAST ULTRASOUND	<input type="checkbox"/> OTHER			
DATE THE CANCER SCREENING TEST WAS PERFORMED:					
AUTHORIZATION					
Several states require that the following statement appear on the claim forms:					
<b>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.</b>					
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: _____		

## FRAUD WARNING NOTICES

For use with Claim Forms

### PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**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:** 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: 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.

**FLORIDA:** 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.

**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of 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.

**LOUISIANA:** 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.

**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 who 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.

## FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

### PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**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 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.

**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: 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.

**OREGON:** 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 may be guilty of insurance fraud.

**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:** 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.

**VIRGINIA:** 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.

**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.

**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.

**ALL OTHER 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 subjects such person to criminal and civil penalties.



## Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**  
**Mail: Post Office Box 427 Columbia, South Carolina 29202**  
**Phone: (866) 849-0011 Fax (866) 849-2970**  
**Email: [groupclaimfiling@caicworksites.com](mailto:groupclaimfiling@caicworksites.com)**

I would like to:		
<input type="checkbox"/> Start <input type="checkbox"/> Stop <input type="checkbox"/> Change direct deposit of my claim payment(s).		
Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
<b>**** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.</b>		
9-Digit Routing Number:	Account Number:	
<i>Remember: The 9-digit number on a deposit slip is <u>not</u> a routing number. You can obtain the routing number from a check or from your financial institution. See example above.</i>		
Name of Financial Institution:		
Address:	City:	
State:	Zip:	Phone:

### Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-866-849-0011.	
Certificateholder's Name ( <i>print</i> ):	
Address:	City/State:
Zip:	Phone #:
Employer Name or Group #:	Certificate #:
<b>Signature:</b>	<b>Date:</b>

INSURED \_\_\_\_\_ COVERAGE ID/POLICY NUMBER \_\_\_\_\_

**AUTHORIZATION TO OBTAIN INFORMATION  
CONTINENTAL AMERICAN INSURANCE COMPANY**

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

**Disclosure of Health Information**

Health information may be disclosed by any health care provider, health plan (including CAIC with respect to other CAIC or coverage's) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, or any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

\_\_\_\_\_  
(Printed Name of Individual Subject to Disclosure)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date Signed)

If applicable, I signed on behalf of the insured as \_\_\_\_\_  
(Indicate relationship, legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.)

\_\_\_\_\_  
(Printed Name of Legal Representative)

\_\_\_\_\_  
(Signature of Legal Representative)

\_\_\_\_\_  
(Date Signed)