1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO *CBP or*
4. E-mail: Team2@cbpinsure.com

Co-Ordinated Benefit Plans
P.O. Box 23802
Tampa, FL 33623
Phone: 877-442-7029
Fax: 800-561-8084

Policy Name:
United Business Association
Policy Number:
US1068698

Critical Illness Claim Form

1. Claimant's Name (Insured)	2. Social Security Number	3. Gender ☐M ☐F	4. Date of Birth	5. E-Mail

6. Address of Claimant and Best Contact Phone Number (Include Area Code)

7. If claim is on a dependent please complete the following: ☐Spouse ☐Domestic Partner/ Civil Union ☐Child/Stepchild	8. Dependent's Name	
9. Dependent's Date of Birth	10. Dependent's Social Security Number	11. Dependent's Address if Different

Critical Illness Information

☐ **Invasive Cancer**: A malignant tumor, characterized by the uncontrolled growth and spread of malignant cells that invade tissue, blood or the lymphatic system.

☐ **Heart Attack (Myocardial Infarction):** The death of a portion of the heart muscle (myocardium) due to a blockage of one or more of the coronary arteries and resulting in the loss of normal function of the heart.

☐ **Stroke:** A cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than 24 hours and resulting measurable neurological deficit persisting for at least 30 days after the occurrence of the stroke

See your policy for complete definitions, benefits and exclusions

12. Describe condition or illness

13. Date you were first seen for this condition	14. Confirmed diagnosis date	15. Have you ever been hospitalized for the same or similar condition ☐Yes ☐No

16. If Yes to question 15 provide name and address of hospital

17. Reason for prior hospitalization

18. Are you currently hospitalized for your current condition?
☐Yes ☐No

19. If yes to question 18 provide name and address of hospital

20. Name and address of treating physician

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.

21. Signature of claimant

22. Date

In order to process your claim additional documentation may be required.
Medical records, pathology reports, office visit notes, EKG scans and/or various other records.
Please complete and return page 3 along with this claim form so we may request these documents on your behalf.

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

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.

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.

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 fins 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.

FLORIDA WARNING :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.

KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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

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

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 and 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.

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.

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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: Any person who, with the 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 have violated state law.

Authorization for Release of Medical Information

Patient Name_____

Date of Birth_____/_____/_____Social Security #_____-_____-_____

I,_____patient of_____(physician name)
am authorizing Co-Ordinated Benefit Plans, LLC to use and/or disclose my health information as identified below to:

Name of Provider _____
Address: _____
_____
Phone Number _____
Fax Number _____

For the following purpose(s): Describe each purpose; if requested by the patient, you may state "at patient's request"

_[✔]_All Records from_____(date) to_____(date)
_[ ]_Initial Exam Records
_[ ]_All Office Records
_[ ]_All Hospital Records
_[ ]_Laboratory / Pathology Reports
_[ ]_Billing / Financial Statements

_____(Initials) I DO (_[ ]_) or I DO NOT (_[ ]_) consent to the release of information relating to psychiatric or psychological testing, alcohol and / or drug abuse diagnosis, prognosis and treatment and /or HIV (AIDS) testing and/or results.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

This consent shall become invalid **one** (**1) year** from the date signed unless a different expiration date, event or condition is specified. Specify:_____

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. I have the right to receive a copy of this authorization.
3. A copy or facsimile of this authorization is as valid as the original.

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name or Print Name of Legal Representative Relationship to Individual

Mail To: Co-Ordinated Benefit Plans, LLC
P.O. Box 23802
Tampa, FL 33623

or

Fax to: 800-560-6340

Phone: 877-442-7029