The Chesapeake Life Insurance Company®
P.O. Box 982015
North Richland Hills, TX 76182-8015

Supplemental Insurance Claim Form Packet

The Chesapeake Life Insurance Company strives to provide easy and accurate claim filing information to our Insured. This packet contains all the required forms for submission of a claim for Supplemental insurance benefits. Follow the Claim Form Guide below and the instructions included on the Claim Forms to submit your complete claim.

Claim Form Guide

What form and information do I need to submit?

The following is a guide for the forms within this packet necessary to file a claim based on the type of loss incurred*.

Additional instructions are included on each Claim form. Please complete all required fields on the necessary forms and attach additional documentation identified in the instructions on each form at the time of submission of your claim**.

Illness/Sickness Claim
(Including Cancer or other critical illness)

- ☐ *Illness and Sickness Claim Form, page 3*
- ☐ *Claims Authorization for the Release of Information, page 2*

Accidental Injury Claim

- ☐ *Accidental Injury Claim Form, page 4*
- ☐ *Claims Authorization for the Release of Information, page 2*

Disability Income Claim

- ☐ *Patient Disability Income Claim Form, page 5*
- ☐ *Physician Total Disability Statement, page 6*
- ☐ *Employer Total Disability Statement, page 7*
- ☐ *Claims Authorization for the Release of Information, page 2*

Where do I mail my form(s) and information?

The Chesapeake Life Insurance Company
P.O. Box 982015
North Richland Hills, TX 76182-8015
Or Fax to 1-817-255-8197

**Additional information may be requested based on the type of loss incurred to determine eligibility for benefits according to the terms of your policy.*

***Missing or incomplete information could result in a delay in processing your claim.*

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Claims Authorization for the Release of Information

(Please Retain a Copy for your Records)

Purpose: This form is requested so that The Chesapeake Life Insurance Company may collect information in connection with a claim for benefits on:

Insured or Dependent Child Name:	
Policy Number:	

Section A: Medical Information Request

By my signature below, I authorize the release of medical information by all health care providers, including physicians, pharmacies, clinics, hospitals, pharmacy benefit manager and any other institution, who has provided health care services, or has record of such services provided, to me or my dependent child listed above to The Chesapeake Life Insurance Company in order to determine eligibility of a claim.*

Medical information includes but is not limited to *Physician's Office Notes, Physical Therapy Notes, Complete Hospital Records* for emergency room services, inpatient services and discharge, and all *Diagnostic Testing Results* (including radiology, pathology and laboratory results).

Section B: Other Information Request

By my signature below, I authorize the release of any applicable police or incident reports necessary to determine eligibility of a claim.

Section C: Expiration and Revocation

I understand that this authorization is valid for two years from the date shown below. I understand that I may revoke this authorization at any time by giving written notice of my revocation. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you receive my written notice of revocation, but may result in a claim being denied or may otherwise adversely affect a pending insurance action. I understand that I have the right to receive a copy of this authorization.

Section D: Re-Disclosure

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance.

Printed Name of Insured: _____

Insured Signature:
Or Authorized Representative _____

Date: _____

If this authorization is signed by an individual's personal representative, please attach a copy of the legal document appointing you to act in this capacity.

**A Special Authorization may be requested by the Physician or Facility*

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Illness / Sickness Claim Form

Instructions:

1. Complete the below *required fields if your claim is due to illness/sickness, sign and date
2. Attach the following documentation for proof of loss
   a. Itemized Bill of Services (must include the date(s) of service and service(s) incurred as a result of the illness/sickness)
   b. Proof of Diagnosis (this can be included on the original itemized bill or physician signed *Physician's Statement* on page 8 in the claim form packet)
   c. *Claims Authorization for the Release of Information, page 2*

Policy Number*	Primary Insured Name*

Patient Name and Date of Birth*	____/ ____ / _____
Relationship to Primary Insured*	☐ Self ☐ Spouse ☐ Dependent

Mailing Address (Street)*		
City*	**State***	**Zip Code***
Phone Number*	**Email:**	

Claim Form Fraud Warning

I agree that all statements and answers in this Form are true to the best of my knowledge and belief. I also understand 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. (See State Specific Claim Form Fraud Warnings on page 9)

Signature: _____ Date: _____

Does the patient have any other Medical or Supplemental insurance including but not limited to Worker's Compensation, Medicare, Medicaid or any other State program? ☐ Yes ☐ No
If yes please provide the name and phone number of Carrier(s): _____

Nature of illness/sickness* _____

Date illness/sickness began* _____

Date of Treatment(s)/Service(s)* _____
Please include initial and on-going visits to a physician or facility

Primary Physician/Facility* _____

Phone Number* _____

Address* _____

Physician(s) seen in the last 5 years* _____

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Accidental Injury Claim Form

Instructions:

1. Complete the below *required fields if your claim is due to accidental injury, sign and date
2. Attach the following documentation for proof of loss
   a. Itemized Bill of Services (must include the date(s) of service and service(s) incurred as a result of the accidental injury)
   b. Proof of Diagnosis (this can be included on the original itemized bill or physician signed *Physician's Statement* on page 8 in the claim form packet)
   c. Applicable Accident, Incident, or Police Report(s)
   d. *Claims Authorization for the Release of Information, page 2*

Policy Number*	Primary Insured Name*

Patient Name and Date of Birth*	____/ ____ / _____
Relationship to Primary Insured*	☐ Self ☐ Spouse ☐ Dependent

Mailing Address (Street)*		
City*	**State***	**Zip Code***
Phone Number*	**Email:**	

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Signature: _____ Date: _____

Does the patient have any other insurance including but not limited to Worker's Compensation, home owners, auto, Medicare, Medicaid or any other State program? ☐ Yes ☐ No
If yes please provide the name and phone number of Carrier(s): _____

Nature of Accidental Injury* _____

Date of Accidental Injury* _____

Date of Treatment(s)/Service(s)* _____
Please include initial and on-going visits to a physician or facility

Primary Physician/Facility* _____

Phone Number* _____

Address* _____

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Patient Disability Income Claim Form

Instructions:

1. Complete the below Information if your claim is due to total disability
2. Have the primary treating physician for your total disability complete the *Physician Total Disability Statement, page 6*
3. Have your employer complete the *Employer Disability Statement, page 7*
4. Provide proof of income for the last 12 months prior to disability (can be provided in the form check stubs, tax return or bank statements)
5. Complete the *Claims Authorization for the Release of Information, page 2*
6. Attach a copy of the Physician's office notes/medical records for support. If you cannot provide this information it will be obtained on your behalf with the signed *Claims Authorization for the Release of Information*.

NOTE: This Claim Form and information above must be completed and submitted each time a scheduled follow-up with your physician occurs for your disability, or monthly if no follow-up is scheduled with your physician within 3 months.

Policy Number	Primary Insured Name
Patient Name and Date of Birth	____/ ____ / _____
Relationship to Primary Insured	☐ Self ☐ Spouse ☐ Dependent

Mailing Address (Street)	
City	**State**
Phone Number	**Email:**

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Signature: _____ Date: _____

Total Disability Details	
Do you have any other insurance including but not limited to workers' compensation, disability income through your employer, or Social Security disability? ☐ Yes ☐ No **Name of Company:** **Phone Number:**	
Reason for Total Disability (Describe the Illness or Injury)	
Please describe all your specific duties during a full work day(including hours of sitting or standing, lifting, or other physical actions)	
Date Illness or Injury Occurred ____/ ____ / _____	Date of First Treatment ____/ ____ / _____

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Physician Total Disability Statement

(Must be completed and signed by a Qualified Licensed Physician)

Instructions:

1. Complete the Information for the patient below.
2. Attach a copy of the Physician's office notes/medical records for support. If you cannot provide this information it will be requested on behalf of the patient with the signed *Claims Authorization for the Release of Information* form

NOTE: This Claim Form and information above must be completed and submitted for each time a scheduled follow-up occurs for disability or monthly if no follow-up is scheduled within 3 months.

Policy Number	Patient Name and Date of Birth
	____/____/_____

Claim Form Fraud Warning

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Physician's Signature	License # and State
Complete Address	
Date	Telephone

Disability Details		
Reason for Total Disability (Describe the Illness or Injury)		
In consideration of the patient's full work day duties described by the patient in the *Patient Disability Income Claim Form*, please describe any portion if any of these duties the patient can NOT perform. Please Explain:		
Please describe the treatment plan for recovery for the patient.		
Date Total Disability Began ____/ ____ / _____	Date of Next Follow-up ____/ ____ / _____	Expected Date of Patient's Return to Partial or Full duties ____/ ____ / _____

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Employer Total Disability Statement

Instructions:
1. Complete the Information for the employee below

Policy Number	Employee's Name and Date of Birth
	____/____/_____

Claim Form Fraud Warning

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Employer's Name _____ Telephone Number (___) _____

Address _____ Fax Number (___) _____

Printed Name of Person Completing Form _____

Signature of Authorized Representative _____

Title _____ Email _____ Date _____ /_____/_____

Total Disability Details

Date Employee Last Worked: ____/ ____ / _____

Reason for stopping work:
☐ Sickness ☐ Injury
☐ Laid Off ☐ Dismissed
☐ Other _____

Has the employee returned to work?

☐ Yes: ☐ Part-Time Date: ____/ ____ / _____ ☐ Full-Time Date: ____/ ____ / _____

☐ No: If No, What is the expected date to return to work: ____/ ____ / _____

Is the Employee's condition work related or did the injury occur at work? ☐ Yes ☐ No

Has Workers' Compensation or Occupational Disease claim been filed? ☐ Yes ☐ No

Is the Employee allowed to work from their home? ☐ Yes ☐ No

What are the major tasks of the employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks (and submit a job description)

_____ _____ %
_____ _____ %
_____ _____ %

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Physician's Statement

(Must be completed and signed by a Qualified Licensed Physician)

Instructions:

1. Complete the below fields, sign and date the Disclosure and Agreement at the bottom of the form
2. Attach the following documentation for proof of treatment incurred by the patient
   a. Medical Records** including but not limited Physician's notes and test results

***NOTE: Records may be requested by The Chesapeake Life Insurance Company upon receipt of Claims Authorization for the Release of Information with claim submission from the Primary Insured or Patient.*

Policy Number	Primary Insured Name

Patient Name and Date of Birth	____/ ____ / _____

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Physician's Signature	License # and State
Complete Address	
Date	Telephone

What is the nature of the Patient's condition? ☐ Illness/Sickness ☐ Accidental Injury

Diagnosis: _____

Date of onset of the condition/date of accidental injury: _____

Has the patient ever had the same or similar condition? ☐ Yes ☐ No
If yes, please provide details:

_____

Please list all Service(s)/Procedure(s) including visits, testing, surgery or hospitalization the patient has had under your care.

Date of Service/Procedure	Description

(Include any additional service(s)/procedures on separate attachment or provide copies of medical records)

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STATE-SPECIFIC CLAIM FORM FRAUD WARNINGS

Before signing the claim form, please read the specific warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, California, Louisiana, Maryland, Minnesota, New Mexico, 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.
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, New Jersey: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
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.
D.C.: 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. An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant
Delaware, Idaho, Indiana and 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.
Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.
Kentucky, Ohio: 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, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.
New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.
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 $5000 and the stated value of the claim for each such violation.
Oregon: Any person who knowingly presents a false statement of claim for insurance maybe guilty of insurance fraud and may be subject to criminal and civil penalties.
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.
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.