TheStandard®

Standard Insurance Company
800.634.1743 Tel 833.289.5001 Fax
PO Box 2800 Portland OR 97208
SupplementalNewClaim@standard.com

Indiana University Critical Illness Benefits Claim Instructions

Your Critical Illness Benefit Claim

This packet contains the forms necessary to apply for Critical Illness Benefits. Every space on these forms should be filled in to avoid delay in processing your application. If a section does not apply, or information is not available, write **"NA"** in the space so that we know you did not overlook that particular question. **If a form is received incomplete, it may be returned for completion.** For specific information about your Critical Illness insurance coverage, refer to your group insurance certificate. The group policy and certificate are the ultimate authority for Critical Illness claim decisions

How to Apply For Benefits

Please complete the following forms included in this Critical Illness Benefits Claim Packet. Refer to your group insurance certificate for covered benefits.

1. **Employee's Statement**

   Answer all questions that apply to this Critical Illness Claim and attach any supporting documentation. Additional evidence may be required in order to determine payment of additional benefits under the group insurance certificate.
   Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

2. **Authorization to Obtain and Release Information**

   Please sign and date the Authorization to Obtain and Release Information and attach it to the Employee's Statement. Your signature lets Standard Insurance Company (The Standard) get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain and Release Information also lets The Standard release this information to specific persons.

3. **Attending Physician's Statement**

   Please complete Section A of the form and submit to your Attending Physician.

   Your physician will need to complete all remaining sections. **If you have seen more than one physician for your Critical Illness, a statement should be completed by each physician.** Your physician(s) should mail or fax the completed form directly to The Standard.

You are responsible for making sure all required forms are completed and returned to our office. If you submit claim information by email, please keep in mind that communications via email are not secure. While unlikely, there is a possibility that information can be intercepted in transmission or misdirected and read by other parties besides the person to whom it is addressed. Please consider communicating any sensitive information by fax or mail. If known, please include your Employer Name and Policy Number, Insured's Name and Claim Number on documentation submitted. If you have any questions, please contact your benefit administrator or call our customer service line at 800.634.1743.

Reset

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Indiana University Critical Illness Benefits Employee's Statement

A. About the Insured

Full Name		Employer/Company Name **Indiana University**	
Group Policy No. **135262**	Social Security No.	Date of Birth	
Gender ☐ Male ☐ Female ☐ X	Phone No.	Mailing Address	
City		State	Zip

B. About the Patient – Check One ☐ You ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Child

If the Insured is the Patient, then you do not need to complete this section again.

Full Name	Social Security No.	
Phone No.	Date of Birth	Gender ☐ Male ☐ Female ☐ X

C. About the Critical Illness - Please check the condition(s) that apply to the Patient's Critical Illness Claim. **Refer to your Group Certificate to determine what Critical Illness benefits are covered.**

Condition	Child Diseases	
☐ Cancer	☐ Anal Atresia	☐ Gastroschisis
☐ Carcinoma in Situ	☐ Anencephaly	☐ Hirschsprung's Disease
☐ Coronary Artery Bypass	☐ Biliary Atresia	☐ Hypoplastic Left Heart System
☐ End Stage Renal (Kidney) Failure	☐ Cerebral Palsy	☐ Infantile Hypertrophic Pyloric Stenosis
☐ Heart Attack	☐ Cleft Lip or Palate	☐ Muscular Dystrophy
☐ Major Organ Failure	☐ Club Foot	☐ Omphalocele
☐ Stroke	☐ Coarctation of the Aorta	☐ Patent Ductus Arteriosis (PDA)
	☐ Cystic Fibrosis	☐ Spina Bifida Cystica with Myelomeningocele
	☐ Diaphragmatic Hernia	☐ Tetralogy of Fallot
	☐ Down's Syndrome	☐ Transposition of the Great Arteries

Other Conditions (may vary by Group Certificate) _____

_____

Date of diagnosis _____

Is this a Critical Illness for which you have previously filed a claim? ☐ Yes ☐ No

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D. About the Physician(s) and Hospital(s) – Please provide the following information about the Patient's current treatment provider(s) for the Critical Illness claim. If treated by more than 2 providers, include the additional information on a separate sheet of paper.

Primary Care Physician Name	Specialty	Date of First Visit for this Condition	
Address	City	State	Zip
Phone No.	Fax No.		

Treating Physician Name	Specialty	Date of First Visit for this Condition	
Address	City	State	Zip
Phone No.	Fax No.		

Please list any recent hospital visit(s)/admission(s) for the Critical Illness claim. Include additional information on a separate sheet of paper if needed.

Hospital Name			
Date Admitted	Date Discharged		
Address	City	State	Zip
Phone No.	Fax No.		

E. Additional Benefits Claimed – Please note the availability of additional covered benefits depends upon your group certificate.

☐ Lodging Benefit – provide copies of receipts for lodging

☐ Transportation Benefit – provide copies of receipts for travel or provide mileage here if traveled by personal car _____

F. Acknowledgement

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 acknowledge that I have read the fraud notices on page 4 of this Claim Packet.

Signature of Insured Member _____ Date _____

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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.

CALIFORNIA RESIDENTS

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

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 the 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.

DISTRICT OF COLUMBIA RESIDENTS

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 RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an 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.

NEW HAMPSHIRE RESIDENTS

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 RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO RESIDENTS

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 RESIDENTS

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

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 RESIDENTS

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.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Authorization to Obtain and Release Information

This authorization applies to the records of _____ who is hereinafter referred to as **"Individual"**.
(Print legibly)

I AUTHORIZE THESE PERSONS having any record or knowledge of Individual:

- Kaiser Permanente, any other health care provider, medical practitioner, coroner, prescription service, hospital, clinic, pharmacy, or other medical or medically related facility or association.
- Any health plans and insurance companies.
- Any employer, policyholder or plan sponsor.
- Any entity administering a benefit, leave or annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency *(for example, Law Enforcement, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.)*.

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records, death certificate, autopsy or toxicology reports, and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis, treatment and recommendations of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.
- Any non-medical information requested about Individual, including such things as investigative reports, including accident or incident reports, education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO: Standard Insurance Company, The Standard Life Insurance Company of New York and any authorized representative for one or both of them (hereinafter all collectively referred to as "The Companies") AND my Employer's Absence Management Program Administrator ("Absence Manager").

I ACKNOWLEDGE AND UNDERSTAND:

- Any prior restrictions on disclosure of Individual's protected health information do not apply to this authorization and I instruct the persons and organizations identified above to disclose Individual's entire medical record without restriction;
- Each of The Companies and Absence Manager will gather Individual's information only if they are administering or deciding any claim(s) for benefits or leave of absence applicable to Individual, and will use the information to determine Individual's eligibility or entitlement for benefits or leave of absence;
- I may refuse to sign this authorization. I may revoke this authorization at any time by sending a written statement to The Companies and Absence Manager. However, a revocation does not apply to disclosures already made under an authorization;
- A revocation of, or the failure to sign, the authorization may impair The Companies and Absence Manager's ability to evaluate or process claim(s), and may be a basis for denying or closing claims for benefits or leave of absence;
- While performing their business The Companies and Absence Manager may disclose information about Individual as allowed or required by law, for example to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with a claim;
- The Companies and Absence Manager will release information to Individual's employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of the employer's self-funded (and not insured) disability plans;
- The Companies and Absence Manager comply with applicable privacy laws. The information disclosed to them may be subject to redisclosure as permitted or required by law. Information retained and disclosed by the Companies and Absence Manager is not protected under the Health Insurance Portability and Accountability Act (HIPAA).

DURATION:

- This authorization as used to gather information shall remain in force for the duration of Individual's claim(s) or 24 months from the date signed below, whichever occurs first.
- The Companies and Absence Manager may share information with each other regarding Individual's claims and leave of absence for 12 months from the date signed below.

I acknowledge that I have read this authorization and the New Mexico notice that follows. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Social Security No. _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, Guardian, Conservator, Personal Representative, Executor), please attach documentation of legal status.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review Individual's confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to Individual. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish Individual to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that they are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

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Indiana University
Critical Illness Benefits
Attending Physician's Statement

Instructions

- Insured or Patient to complete section A and submit to Attending Physician for completion.
- Attending Physician to complete sections B and C.
- Attending Physician to submit the completed and signed Attending Physician's Statement and supporting documentation to the address or fax number listed above.

A. About the Insured and the Patient

Insured's Information

Full Name	Employer/Company Name **Indiana University**	Group Policy No. **135262**
Social Security No.	Date of Birth	Phone No.

Mailing Address	City	State	Zip

Patient's Information

Full Name	Social Security No.	Date of Birth	Gender ☐ Male ☐ Female ☐ X

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Child

B. About the Condition(s) Causing the Critical Illness and Treatment – to be completed by Attending Physician. The Patient is responsible for obtaining a complete form without expense to The Standard.

Please check the condition(s) that apply to this Patient and attach supporting documentation, such as test results, clinical diagnoses, imaging results, operative reports, pathology reports and/or your detailed medical statement.

Condition	Child Disease
☐ Advanced Alzheimer's Disease	☐ Anal Atresia
☐ Advanced Multiple Sclerosis	☐ Anencephaly
☐ Advanced Parkinson's Disease	☐ Biliary Atresia
☐ Amyotrophic Lateral Sclerosis (ALS)	☐ Cerebral Palsy
☐ Benign Brain Tumor	☐ Cleft Lip
☐ Bone Marrow Transplant	☐ Cleft Palate
☐ Cancer	☐ Club Foot
☐ Carcinoma in Situ	☐ Coarctation of the Aorta
☐ Coma	☐ Cystic Fibrosis
☐ Coronary Artery Bypass	☐ Diaphragmatic Hernia
☐ End Stage Renal Failure	☐ Down's Syndrome
☐ Loss of Hearing	☐ Gastroschisis
☐ Loss of Sight	☐ Hirschsprung's Disease
☐ Loss of Speech	☐ Hypoplastic Left Heart System
☐ Major Organ Failure	☐ Infantile Hypertrophic Pyloric Stenosis
☐ Myocardial Infarction	☐ Muscular Dystrophy
☐ Occupational Hepatitis	☐ Omphalocele
☐ Occupational HIV	☐ Patent Ductus Arteriosis (PDA)
☐ Paralysis	☐ Spina Bifida Cystica with Myelomeningocele
☐ Stroke	☐ Tetralogy of Fallot
	☐ Transposition of the Great Arteries

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Primary Diagnosis _____

Date of Diagnosis _____

Date first consulted for this condition _____ Date of first symptoms _____

Has the patient been hospitalized? ☐ Yes ☐ No

If Yes, give Admission Date _____ Discharge Date _____

Name of Facility/Hospital where this patient was treated (including City and State) _____

_____

Has this patient been treated for this same or similar condition prior to this occurrence? ☐ Yes ☐ No

If Yes, please provide diagnosis, dates of treatment and names of other medical providers. Include additional information on a separate sheet of paper if needed _____

_____

C. Attending Physician Information, Acknowledgement and Signature

Name of Physician _____ Specialty _____

Address _____

City _____ State _____ ZIP _____

Phone No. _____ Fax No. _____

Acknowledgement

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 acknowledge that I have read the fraud notice on page 9 of this form.

Physician's Signature _____ Date _____

Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND RESIDENTS

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CALIFORNIA RESIDENTS

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COLORADO RESIDENTS

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DISTRICT OF COLUMBIA RESIDENTS

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NEW YORK RESIDENTS

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ALL OTHER RESIDENTS

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