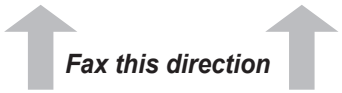
Fax to: Claims 1.800.880.9325
From: _____ Number of pages:_____



Or Mail to:
P.O. Box 100266
Columbia SC 29202-3266

Colonial Life®
Making benefits count.

Universal Claim Form

Please be sure to send the following Information:

- ✓ **Medical Documentation for your condition**
- ✓ **Diagnosis (ICD9) codes,**
- ✓ **Signed and dated authorization**

OPTIONAL SERVICE RELEASE AGREEMENT – Please **initial** below for optional services. Any other marks used (check mark, x, etc.) will not be considered as authorization and will be processed as blank.

I authorize Colonial Life to facilitate processing this claim by releasing its details to the individual inquiring on my behalf. Leave blank if you do not want anyone accessing your claim information.

_____sales representative _____plan administrator

_____spouse, family member or significant other

_____I want Colonial Life to update me on the status of my claim through electronic messaging at my home phone number indicated on this form. Messages will be left with anyone that answers the phone or on my answering machine. To avoid blocked calls, I should program the number 1.800.325.4368 into my phone.

_____Yes, I want **ALL** payment(s) for this claim sent by overnight delivery. I understand payment(s) under $100.00 cannot be sent overnight and an $18.00 fee, which is subject to rate increases by carrier and **does not include weekend delivery, will be deducted from my claim payment(s). We are unable to overnight mail to a P.O. Box and you must notify us in writing to discontinue this service.**

***WELLNESS/HEALTH SCREENING**

If you wish to file a **Wellness/Cancer Screening claim for a test performed within the past 12 months**, we need to submit the type and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number. **You may:**

- **FILE BY PHONE!** Call **1.800.325.4368** and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week, **or**
- **SUBMIT ON THE INTERNET** using the Wellness Claim Form at **coloniallife.com**, or
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "**Wellness Test**." **FAX** this to us at **1.800.880.9325 *or* MAIL** to P.O. Box 100195, Columbia SC 29202.

If you file by telephone or internet please retain a copy of the medical information and/or your receipt if needed for further verification.

If your Wellness/Cancer Screening test was more than one year ago, you must fax or mail us a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.

Please note: If your cancer policy includes a second part to the screening benefit, bills for covered tests and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

***CANCER**

Please complete the sections that apply to your coverage.

- For ***Internal Cancer*** – **Attach** a copy of the **pathology report** from your *initial* diagnosis.
- Attach copies of itemized statements for all medical expenses incurred relating to the diagnosis and treatment of your malignancy. Please clearly write your name and social security number on each bill.
- For ***Skin Cancer*** – Attach a copy of your pathology report for *each date of service* a lesion was biopsied and/or removed. Also, please include a copy of your itemized bills that provide the surgical procedure code(s) and charges for each lesion removed. This information should provide all doctors complete names, mailing addresses and telephone numbers.
- ***Transportation and Lodging*** – Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.
- ***If you are claiming disability, please have your employer and doctor provide any applicable information under SECTIONS 5 & 6.***

Claim Fraud Statements

For your protection, the laws of several states, including Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Minnesota, New Hampshire, Ohio, Oklahoma, and others require the following statement to appear on this claim form.
Fraud Warning : Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Arizona Residents : 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.

California, Texas and West Virginia Residents : For your protection, California, Texas and West Virginia law requires the following to appear on this form: Any person who knowingly presents 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 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 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.

District of Columbia and Maryland 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 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.

Kentucky : For your protection, Kentucky law requires the following to appear on this form: 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.

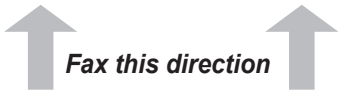
Maine, Tennessee, Virginia and Washington Residents : It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

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

Oregon Residents : Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Puerto Rico Residents : 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 (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If 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.



Fax to: Claims 1.800.880.9325
Phone Number: 1.800.325.4368

If your name has changed, please attach a copy of legal documentation (i.e. marriage certificate or driver's license)

SECTION 1 TO BE COMPLETED BY POLICY OWNER

Claimant name __Male __Female	Birth Date	Claimant Social Security Number
Relationship to Policy Owner: ___ spouse ___ dependent ___self ____domestic partner		
Policy owner (First, Last)	Birth Date	Social Security Number
Mailing Address (Street or PO Box)		(Apartment/Unit/Lot number)
(City) (State) (Zip)		Home telephone number ( )
Policy owner e-mail address *(*Please print)*		Work telephone number ( )
Treating Doctor's Name	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
Primary Doctor's Name	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
Referring Doctor or Hospital Name	Phone Number	Fax Number
Address (Street) (City) (State) (Zip Code)		
Referring Doctor or Hospital Name	Phone Number	Fax Number

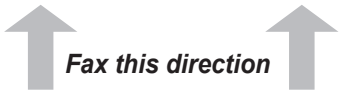
SECTION 2 TO BE COMPLETED BY POLICY OWNER

ACCIDENTAL INJURY- please **complete** and **attach itemized copies** of any related **bills** including **doctor**, **ambulance, emergency room, hospital, and/or rehabilitation unit**. Bills should include **diagnosis** information from your medical provider.

Date the accident occurred (not when it was treated) _____ (MM/DD/YYYY)	Have you been treated for the same or similar condition prior to this occurrence? ___Yes ___No If yes, when? _____ (MM/DD/YYYY)

Check One:_____On-Job_____Off-Job

Description of accident (if auto accident, attach a copy of the traffic report)



Fax to: Claims 1.800.880.9325
Phone Number: 1.800.325.4368

CERTIFICATION

Policy owner Name _____ **Social Security #** _____

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the Claim Fraud Statements on page 2 of this form and that I read the statement required by the State department of Insurance for my state, if my state was listed on the form. **Fraud Warning: 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.**

Please remember to also sign and date the attached authorization required to process your claim.

X	X	X
_____	_____	____/____/____
Claimant's Signature	Policy owner's Signature	Date (MM/DD/YYYY)

SECTION 3 TO BE COMPLETED BY PHYSICIAN

ROUTINE PREGNANCY (6 weeks for vaginal delivery or 8 weeks for c-section, less the elimination period)

Date of Delivery _____ (MM/DD/YYYY) ___ Vaginal ___C-section	Hospital Admission Date: _____ (MM/DD/YYYY)	Hospital Discharge Date : _____ (MM/DD/YYYY)

First Date of Treatment, Advice, Medication : _____ (MM/DD/YYYY)

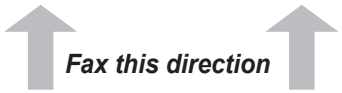
List other Date of Treatments, for this pregnancy : _____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY)

_____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY)

Doctor's Name	Doctor's Phone : ( ) Fax : ( ) Tax ID or SSN:
Doctor's Address (Street) (City)	(State) (Zip Code)

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

Doctor's Signature	Date: _____ (MM/DD/YYYY)
Referring Physician's name and address	Doctor's Phone : ( ) Fax : ( )
Hospital Name	Hospital Phone ( )
Hospital's Address (Street) (City)	(State) (Zip Code)



Fax to: Claims 1.800.880.9325
Phone Number: 1.800.325.4368

SECTION 4 Hospital Confinement/Hospital Intensive Care Unit Confinement Benefits

Refer to your certificate for required proof of loss requirements. Ask your medical provider to complete the following section.
Include a copy of the hospital bill(s) showing the admission and discharge dates, the daily room charge(s) and the medical expenses incurred. Please send a copy of the anesthesiology bill if outpatient surgery was performed.

Hospital Name | Phone Number : ( )

Hospital Address: (Street) (City) (State) (Zip Code)

Admitting Doctor's Name : | Phone Number : ( )

Admitting Doctor's Address: (Street) (City) (State) (Zip Code)

Hospital Confinement Dates : From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

Intensive Care Unit Confinement Dates : From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

Rehabilitation Unit : From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

Surgery/Inpatient : From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

Procedure Description/Procedure Code :

Surgery/Outpatient : From _____ (MM/DD/YYYY) To _____ (MM/DD/YYYY)

Procedure Description/Procedure Code :

Admitting Diagnosis/ICD-9 Code : | Secondary Diagnosis/ICD-9 Codes :

Date(s) of Doctor Office Visit(s) following outpatient surgery :

_____ (MM/DD/YYYY) _____ (MM/DD/YYYY) _____ (MM/DD/YYYY)

If hospital confinement is for pregnancy or pregnancy complications, please provide the date the pregnancy was diagnosed _____ (MM/DD/YYYY)

Date of delivery : _____ (MM/DD/YYYY) Type of delivery : ____Vaginal ____ C-section Procedure Code for delivery _____

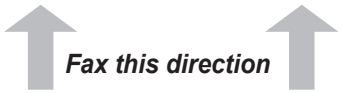
Referring Doctor's Name: | Phone Number : ( )

Referring Doctors Address: (Street) (City) (State) (Zip Code)

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

Doctor's Signature (completing this form): Date :_____ (MM/DD/YYYY)

Tax ID or SSN : Phone Numbers: ( ) Fax Number: ( )



Fax to: Claims 1.800.880.9325
Phone Number: 1.800.325.4368

SECTION 5 TO BE COMPLETED BY PHYSICIAN

Patient's Name | Patient's DOB

What primary condition prevents the patient from working?

Symptoms: | Objective Findings:

Date first treated for this condition ____/____/_____ (MM/DD/YYYY) | If pregnancy, what is EDC? ____/____/____ (MM/DD/YYYY)

Is condition due to accident? ☐ Yes ☐ No If yes, date and description of accident ___/___/___ (MM/DD/YYYY)

Are any secondary conditions preventing the patient from working? ☐ Yes ☐ No | If yes, what are these secondary conditions?

When did symptoms first appear? ____/____/_____ (MM/DD/YYYY) | Date of new patient consultation ____/____/_____ (MM/DD/YYYY) | Date of patient's last visit ____/____/_____ (MM/DD/YYYY)

List any test(s) performed and submit a copy of the results.

List any surgeries performed with the date and procedure code (CPT).
(Attach a copy of the operative report)

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

How soon do you expect significant improvement in the patient's medical condition?
☐ 1-2 months ☐ 3-4 months ☐ 5-6 months ☐ more than 6 months | Expected return to work (MM/DD/YYYY)

Dates (MM/DD/YYYY) unable to work full-time
From: To:

Dates (MM/DD/YYYY) unable to work part-time
From: To:

Actual date released to return to work. ____/____/_____ (MM/DD/YYYY)

Does this patient have permanent restrictions/limitations? ☐ Yes ☐ No

If not employed, list dates of house confinement:
From_____ (MM/DD/YYYY) To_____ (MM/DD/YYYY)

House Confinement means you are kept at home by your condition. "At Home" means in your house or yard. However you may follow your doctor's orders, even if it means leaving home.

Please check the activities of daily living that the patient is unable to perform:

☐ dressing ☐ eating ☐ meal preparation ☐ toileting ☐ continence ☐ bathing ☐ transferring

Dates of Office visit (Last 3 months) | How often do you see the patient?

Have you referred patient for other types of consultation ☐ Yes ☐ No | Name and address of Specialist

Dates of Hospitalization (Last 3 months) | Name and Address of Hospital

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

Signature of Physician | Date (MM/DD/YYYY) | Physician's Specialty

Telephone Number ( ) | Fax Number ( ) | Tax ID or SSN

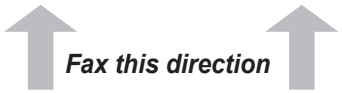
Physician/Group Name | Patient Account Number

Mailing Address | Do you accept Medical Records request by Fax? ☐ Yes ☐ No

Was patient referred to you by another physician? ☐ Yes ☐ No | Do you have authorization on file to release information to Colonial Life? ☐ Yes ☐ No

Provide the following information for referring doctor:
Name: | Phone number ( )

Mailing Address | Fax number ( )



Fax to: Claims 1.800.880.9325
Phone Number: 1.800.325.4368

SECTION 6 TO BE COMPLETED BY EMPLOYER

Employee name_____

Hire date_____

Average number of scheduled hours per week_____

Date last worked_____ (MM/DD/YYYY)

Dates employee unable to work (Full-time)
From_____ (MM/DD/YYYY) AM/PM To_____ (MM/DD/YYYY) AM/PM

Date sick leave was exhausted_____ (MM/DD/YYYY)

Dates approved for FMLA (if eligible)
From_____ (MM/DD/YYYY) To_____ (MM/DD/YYYY)

Date employment terminated_____ (MM/DD/YYYY)

Was employee at work when the accident or sickness occurred?
☐ Yes ☐ No

Is a Workers' Compensation claim being filed?
☐ Yes ☐ No

Name and phone number of Workers' Compensation carrier:

For hourly employees:

Hourly rate of pay _____ Hours worked per week _____

For salaried employees:

Annual salary _____

If salary includes commissions, attach a breakdown of commissions for the twelve months prior to date last worked.

Date returned to work: Full-time_____ (MM/DD/YYYY) Part-time_____ (MM/DD/YYYY)/Hours per week_____

Expected return to work _____ (MM/DD/YYYY)

Employee's job title:

Employee's duties include:

Lifting	☐	Less than 15 lbs.	☐	15 to 44 lbs.	☐	over 45lbs.
Stooping/bending	☐	none	☐	seldom	☐	frequent
Crawling/kneeling	☐	none	☐	seldom	☐	frequent
Reaching/pulling/pushing	☐	none	☐	seldom	☐	frequent
Repetitive motion	☐	none	☐	seldom	☐	frequent
Management Duties	☐	none	☐	seldom	☐	frequent

Sitting (number of hours each day):_____ Standing (number of hours each day)_____

Walking (number of hours each day):_____ Climbing Stairs/Ladders (number of hours each day)_____

Who should we contact for updates on return to work status? Name/Phone/E-mail *(*Please print)*

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Signed by _____ Title _____

Print name _____ Date _____ (MM/DD/YYYY)

Telephone Number ( )_____ Fax Number ( )_____

E-mail Address *(*Please print)* _____

Phone 1.800.325.4368 *Fax 1.800.880.9325*

Authorization for Colonial Life & Accident 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 or claim forms, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record and insurance claim history but does not include psychotherapy notes. Non health information including earnings or employment history or any other facts deemed appropriate by Colonial Life to evaluate my application or claim forms 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 governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating and administering my 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. Colonial Life will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is earlier and a copy 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. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life 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 revoked, Colonial Life may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Claims Department, P. O Box 100195, Columbia, SC 29202-3195.

You may refuse to sign this form; however, Colonial Life may not be able to evaluate and administer your claim. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

X_____ XXX-XX-_____ _____

(Signature) (Social Security Number — last 4 digits) (Date of Birth)

_____ _____

(Printed name of individual subject to this disclosure) (Date Signed)

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

_____ _____ _____

(Printed name of legal representative) (Signature of legal representative) (Date Signed)