CANCER
CLAIMS FAX TRANSMITTAL

Central United Life
Manhattan Life
Family Life

Please Fill in the following lines with your current personal information.

Number of Pages Including Cover: ____________________ Date: ____________________

To: CANCER CLAIMS DEPARTMENT From: ____________________

Email Address: ____________________ Fax: ____________________

Phone Number: ____________________ Policy Number(s): ____________________

Policyholder Name: ____________________

Please Fax Multiple Claims Separately

Claim Type:

☐ Cancer Policy ☐ First Occurrence Benefit

Riders:

☐Mammogram ☐ Premium Waiver
☐Dread Disease ☐Cancer and Dread Disease
☐Chemo & Radiation
☐Intensive Care Unit

Wellness Benefit:

☐Cancer Wellness

All Cancer Claims Should Be Faxed to 713-583-8508

Additional Information: ____

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Please **DO NOT** send more than one claim with each fax transmission.

Each Policy or Covered Person requires a separate fax cover page and a separate fax transmission.

CANCER SCREENING BENEFIT CLAIM FORM

Please check the box beside your insurance company's name.

❒ Manhattan Life Insurance Company ❒ Central United Life Insurance Company

❒ Family Life Insurance Company

◆ PATIENT AND INSURED INFORMATION ◆

Patient's Name ____________ Date of Birth ____________ Policy Number ____________

Address ____________ Social Security Number ____________

Policyholder's Name ____________ Relationship to Policyholder ____________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
authorize any release of any medical information necessary to process this claim, I require payment to myself or to the party who accepts assignments below.

X____________________ DATE ____________

INSURED OR AUTHORIZED PERSON'S SIGNATURE
I certify that the foregoing statements are true and correct. ❒ I DO ❒ I DO NOT authorize payment of medical benefits to undersigned physician or supplier of services described below.

X____________________ DATE ____________

◆ PHYSICIAN OR PROVIDER INFORMATION ◆

Name and Address of Facility Where Services Rendered			Your Patient Account No.	
Date of Service	Place of Service	Please place an X in the box beside the following tests performed	Diagnosis Code	Charges
		❒ Mammography		
		❒ Colonoscopy		
		❒ Flexible Sigmoidoscopy		
		❒ CA 125 (blood test ovarian cancer)		
		❒ Pap Smear (test only)		
		❒ Chest X-ray		
		❒ PSA (blood test for prostate cancer)		
		❒ Hemocult Stool Specimen		
		❒ Serum Protein Electrophoresis		
		❒ Other		

Signature Of Physician Or Provider
NOT APPLICABLE IF STATEMENT IS PROVIDED

X____________________ DATE ____________

Physician's or Supplier's Information

Name ____________

Address, ZIP Code ____________

Physician's Telephone No. ID Number ____________

Claims Department
P. O. Box 925309
Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
www.manhattanlife.com

CSB 1013

PLEASE READ THIS INFORMATION BEFORE SUBMITTING YOUR CLAIM

If you need assistance, please contact our Customer Service Department at 1-800-669-9030.

PLEASE READ YOUR POLICY CAREFULLY

Cancer policies pay benefits for certain specified treatments, procedures and services rendered to the policyholder or named insured for the treatment of cancer. These limited benefit policies pay benefits only for those items listed in your policy. **Since the cancer policy is a specified benefits policy, it does not pay for all treatments, procedures or services you may receive in connection with your cancer treatment.** Please refer to your policy to determine your eligible benefits.

COMPLETE THE CLAIM FORM IN ITS ENTIRETY

Please do not send documents without a completed claim form. Always include your policy number on the claim form and indicate if you have more than one policy with us. Include the area code and telephone number for you and your physician.

COMPLETE A HIPAA FORM

Please complete a HIPAA form, found on our web site, and submit it with your claim. You only need to complete this form once and we will keep the form on file. You do not need to submit a new HIPAA form with each claim. This form can assist us in obtaining additional information on your behalf to help process your claim.

ITEMIZED STATEMENTS

It is your responsibility to provide us with all of the information needed to determine if the services received are a benefit under the policy. Attach all relevant information to your claim form, i.e. itemized statements from each medical provider who treated you and your hospital UB-04s. These statements provide detailed information regarding the treatments, procedures, and services you received from the medical provider. Itemized statements must include:

- The name of the person or organization providing the service, their address, telephone number, and tax identification number
- Name of the patient
- Date each service was provided
- Description of each service
- A dollar amount for each service

PATHOLOGY REPORTS

Every diagnosis of cancer must be supported by a positive pathology report, including the initial and any subsequent diagnosis. Also, a pathology report must be submitted with any surgical claim.

CHEMOTHERAPY AND RADIATION

When you submit a claim for chemotherapy and /or radiation, please ensure that the statements from your providers contain the number of units that were administered.

SURGERY/ANESTHESIA

When submitting a claim for surgery performed to remove cancer, please provide the following:

- A copy of the surgeon's statement
- A copy of the anesthesiology statement, if you had anesthesia
- A pathology report should be submitted with any surgical claim.

PRESCRIPTION DRUGS

Please submit an itemized statement from the pharmacy which shows the name of the drug, the identifying drug number, and the amount paid. Cash register or charge slips are not acceptable.

TRANSPORTATION

If your policy has a transportation benefit provision and you had to travel away from your home to obtain cancer treatment, please provide the following:

- Completed transportation claim form. This form can be found on our web site.
- Any appropriate receipts (i.e. hotel receipts, airline tickets)

ACTUAL CHARGE POLICIES

Some policies contain benefits that are paid based on the actual charge. If you are unsure, please review the chemotherapy, radiation, and blood and plasma benefits in your policy.

If your policy pays benefits based on the actual charges, please submit documents showing the amount the medical provider actually charged – that is, the amount that was paid by or on your behalf to the medical provider as payment in full.

Documents which show the actual charges paid by you or on your behalf include an Explanation of Benefits from your primary insurance carrier.

If you need assistance in determining what documentation to provide, please contact our Customer Service Department at 1-800-669-9030.

A WORD ABOUT OUR EXPLANATION OF BENEFITS (EOB) STATEMENTS

Our EOBs only list those services which are covered benefits under the terms of your policy.

For example, if you submit a claim for chemotherapy administered in a hospital, the statement may contain miscellaneous hospital charges which may not be benefits under your policy.

Only those items that are covered services as indicated in your policy will be listed on the EOB.

Submit Completed Form to:
Claims Department, P.O. Box 925309, Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
www.manhattanlife.com

MANHATTAN

Central United Life Insurance Company
REPORT OF CANCER OR SPECIFIED DISEASE CLAIM

Patient's Name	Date of Birth	Policy Number
Patient's Address		Relationship to Policyholder
Policyholder's Name		Policyholder's Social Security Number
What is the nature of your illness?	Date diagnosed	Date of first treatment
Physician name and address		
Were you hospitalized? ❑Yes ❑No	Date of confinement Through	
Name and address of hospital		
Have you ever had a similar illness? ❑Yes ❑No	If so, when?	

I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by Central United Life, Investors Consolidated or Loyal American or their duly authorized representative to Central United Life, Investors Consolidated or Loyal American. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization is valid for 24 months. Revocation of the authorization must be submitted in writing. I or my authorized representative is entitled to a copy of this authorization.

Policyholder's Signature ______________________________ Date: ____________

Patient's Signature ______________________________
(Required only if patient is spouse or over age 18)

Policyholder's Address ______________________________
Street City State ZIP Code

❑Check if this is a new address.

Important: Failure to complete this form in its entirety or submit the information requested below may result in delay of processing this claim.

Please send the following information to us at the below address so we can process your claim:

- **Itemized statements from your health care providers showing the treatments, services and procedures you received.**
- **All initial diagnosis of cancer must be supported by positive pathology or lab results.**
- **A pathology report for all surgical procedures.**
- **Documents showing the actual charges paid by you or on your behalf (such as Explanation of Benefit from your primary insurance carrier or Statement of Account from your health care provider.)**
- **If your policy has a transportation benefit, please submit a transportation claim form if you think you may be entitled to a transportation benefit.**

Claims Department
P.O. Box 925309
Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
www.manhattanlife.com

MANHATTAN INSURANCE GROUP

Claim Form Addendum: Fraud Warning and State Versions

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.

Alabama 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. **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. **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. **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. **California** For your protection California 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** 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. **Hawaii** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both. **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. **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. **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. **Rhode Island** 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. **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. **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.

Policy Service Form

Please check the box next to your insurance company's name.

❑Central United Life ❑Investors Consolidated ❑American General ❑Loyal American ❑Gold Cross ❑UniLife ❑Unum ❑American States ❑Family Life ❑ Manhattan Life

Name of Owner	Name of Insured	Policy Number
Address, City State of Zip of Owner		
Daytime Telephone Number of Owner Between 8am-4pm CST		

Please place a check mark in the boxes for the changes you wish to make.

1. Address Change – Life and Heath Policy

Address, City, State, and ZIP Code:____________________________
Effective Date of New Address________________ Daytime Telephone Number ________________
Other Family Members at the New Address:____________________________

2. Cancellation of Policy – Life Policy Only – NO CASH VALUE

❑ I hereby request to cancel my policy. This policy has no cash value.

Important: If the policy has a cash value, then you must complete the Life Cash Surrender or Partial Withdrawal Form

3. Dividend Options – Life Policy Only

*Spouse must sign in Agreements section for AZ, CA, ID, LA, NV, NM, TX, WA, and WI.

❑Dividends to be surrendered* ❑Accumulations ❑Paid-up Additions* (select method below)

❑ In Cash $__________
❑ For $________ to pay________ premium due ________on policy number __________
❑ For $________ to apply toward loan on policy number __________.

*Dividends withdrawn or paid-up additions surrendered may not be repaid. If proceeds are to be applied in any other manner, use the "Remarks" section below.

❑Dividend Option Change (Select method below)

❑ Cash to Owner ❑ Accumulate at Interest
❑ Reduce Premium** ❑ Purchase Paid-up Additions

**Available only on the next premium due on the policy anniversary date.

4. Loan Application/Repayment Options – Life Policy Only

*Spouse must sign in Agreements section for AZ, CA, ID, LA, NV, NM, TX, WA, and WI.

❑ Policy Loan Application ❑ Repayment Plan
❑ In Cash $________ ❑ For $________ to pay________ premium due ________ on policy number ________

Loan amount may include portion of dividends unless otherwise requested. I realize that any existing indebtedness or unpaid premiums shall be included in the new loan total. The loan is to be completed with the terms of the policy.

To set up a formal loan repayment plan using ELECTRONIC FUNDS TRANSFER, select one of the following below:
❑ Begin charging my checking account $________ per month. ❑ Add $________ to my existing loan repayment per month.

5. Name Change – Life and Health Policy

❑ Insured ❑ Owner ❑ Payor ❑ Beneficiary ❑ Other
From: ________________ (first middle, last) To:________________ (first, middle, last)
Reason (i.e. marriage, divorce, etc.):________________ Please attach copy of marriage license or divorce decree.

6. Non-Forfeiture Option Election – Life Policy Only

❑ Reduced Paid-up Insurance ❑ Extended Term Insurance Amount:________ Effective Date:________ Expire Date: ________

7. Premium Mode Change – Life and Health Policy

❑ Annual ❑ Semiannual ❑Quarterly ❑ Electronic Funds Transfer (include Bank Draft Authorization Form & voided check)
❑ Premium Amount Change (if policy provisions allow) Amount $________ Effective Date________

8. Removal of Dependents – Life and Health Policy

Name ________________ Date of Birth __________ Reason* __________
*(If due to death then submit death certificate. If due to divorce, then submit the divorce decree)

Remarks - Please use this space for any special instructions you may have regarding the above elections.

AGREEMENTS AND SIGNATURES

Irrevocable beneficiaries or collateral assignees must sign to authorize the transaction(s). The undersigned hereby agree(s) to authorize the transaction(s) as stated above which affect my (our) interest in this policy. I hereby authorize the above transaction(s):

Date: ____________ Owner: ________________

*The owner of the policy must sign. For adult contracts, this would normally be the insured. It could also be a person named as owner on the application or by absolute assignment.

____
Spouse Signature if Community Property State ***Important:** Signature of wife or husband required if owner is a resident of any of the following states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin. If there is no spouse, please indicate such.

ENDORSEMENT/ACKNOWLEDGEMENT BY COMPANY

The above indicated company acknowledges receipt, on this date, of the foregoing instrument at its Administrative Office, and has filed the request or requests therein contained, subject, however, to the express condition that the policy is in full force on the date of such instrument.

Date____________ By Authorized Representative ________________

AFTER ACKNOWLEDGEMENT BY THE COMPANY, THIS FORM SHOULD BE FILED WITH THE POLICY.

Submit Completed Form to: Policyholder Services, P.O. Box 925989, Houston, TX 77292
Customer Service Department 1-800-669-9030
www.manhattanlife.com

MANHATTAN INSURANCE GROUP

Please check the box beside the name of your insurance company.

☐ American States ☐ Central United Life ☐ First Unum ☐ American General
☐ Gold Cross Burial Association ☐ Investors Consolidated ☐ Unilife
☐ Loyal American ☐ Manhattan Life ☐ Unum ☐ Family Life

INDEMNIFICATION AGREEMENT

To: Financial Institution named on this form.

In consideration of your compliance with the request and authorization of the depositor:

THE COMPANY REFERENCED ABOVE AGREES THAT:

1. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any debit drawn by the company referenced above to its own order in the account of such person, or from any liability to any such person or to any owner or beneficiary of any policy issued by the company referenced above in respect of which such a debit is drawn by the company referenced above, provided there are sufficient funds in such account to pay the same upon presentation, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture of a policy the premiums on which is sought to be collected by the company referenced above by such debit; and,
2. It will refund to you any amount erroneously paid by you to the company referenced above on such debit if claim for the amount of such erroneous payment is made by you within twelve months from the date of the debit on which such erroneous payment was made.

President

AUTHORIZATION TO HONOR DEBITS DRAWN BY COMPANY REFERENCED ABOVE

To: ____
(Print Name and Address of Financial Institution where Account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my account debits drawn on my account by and payable to the order of – the company referenced above - provided there are sufficient collected funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of and rights in respect to each such debit shall be the same as if it were signed by me. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

Account Title: ______________________________

Account Number: ______________________________

ABA Routing Number: ______________________________

Date of Withdrawal: ______________________________
(Cannot select the 29th, 30th, or 31st)

Account Type: ☐ Checking ☐ Savings

Policy Number: ______________________________

Signature(s) X ______________________________

X ______________________________

PLEASE ATTACH A VOIDED CHECK

Return the completed form to:
P.O Box 925688
Houston, Texas 77292-5688

Comments:

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MANHATTAN INSURANCE GROUP