Cancer Claim Statement

For your protection, the following disclosures are required by state law and are based on the state where you live:

If you live in New York the following statement applies to you:

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.

If you live in the state of Alaska, the following statement applies to you:
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.

If you live in the state of Alabama, the following statement applies to you:
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.

If you live in the states of Arkansas, Louisiana, Massachusetts, Minnesota, New Mexico, Rhode Island, Texas or West Virginia, the following statement applies to you:
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.

If you live in the state of Arizona, the following statement applies to you:

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.

If you live in the state of California, the following statement applies to you:
For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

If you live in the state of Colorado, the following statement applies to you:
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.

If you live in the District of Columbia, the following statement applies to you:
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.

If you live in the states of Delaware, Idaho or Indiana, the following statement applies to you:
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.

Listed below is our Benefit Center and corresponding address, toll-free number, fax number and E-mail:
Sun Life Financial 300 Southborough Drive, Suite 200 South Portland, ME 04106-6914
• T 877.820.5306 • F 866.376.9480 SLFWorksiteclaims@disabilityrms.com

If you live in the state of Florida, the following statement applies to you:
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.

If you live in the state of Kansas, the following statement applies to you:
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 may be guilty of insurance fraud as determined by a court of law.

If you live in the state of Kentucky, the following statement applies to you:
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.

If you live in the state of Maryland, the following statement applies to you:
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.

If you live in the state of Maine, the following statement applies to you:
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.
If you live in the state of New Hampshire, the following statement applies to you:
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.

If you live in the state of New Jersey, the following statement applies to you:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

If you live in the state of Ohio, the following statement applies to you:
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.

If you live in the state of Oklahoma, the following statement applies to you:
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.

If you live in the states of Oregon or Virginia, the following statement applies to you:
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 may have violated state law.

If you live in the states of Tennessee or Washington, the following statement applies to you:
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.

If you live in the state of Vermont, the following statement applies to you:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

If you live in a state other than mentioned above, the following statement applies to you:
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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages

Insured Employee Instructions for filing a Cancer Claim.

1. Complete Part 1 and Part 4.
2. Complete Part 2 or Part 3 if filing for a dependent.
3. Have the physician complete Part 5.
4. Sign and date the Authorization Sections.
5. Provide Documentation:

Attach itemized bill or medical insurance Explanation of Benefits (EOB) for each charge to be considered. Some documentation can be obtained by requesting a copy of the hospital bill (UB04) or HCFA1500 (non-hospital bill) from your healthcare provider.

Please include the following documents for all that apply:
Hospital: copy of hospital bill indicating diagnosis, treatment, services and days hospitalized
Surgical: a copy of the operative report
Medical: a copy of medical bills indicating the treatment received and/or services rendered
Ancillary: a copy of bills for ambulance, lodging, transportation, or other care or covered services

Cancer Screening Benefit: See policy for covered tests or procedures. If submitting a claim for this benefit use **Cancer Screening Claim Statement (KC4916).**

HIPAA Authorization For Release of Protected Health Information

Sun Life Financial®

Insured/Member name _____ SSN _____ DOB _____

Claimant name _____

Address _____ City _____ State _____ Zip _____

Policy no. _____ Participation no. _____ Account no. _____ Certificate no. _____

Persons/categories of persons providing the information: Any provider of medical services, insurance or reinsurance company or their authorized representatives, pharmacy, pharmacy benefits manager, or any pharmacy-related service entity, Social Security Administration, governmental agency, consumer reporting agency, vocational provider or employer having medical information, with respect to any physical or mental condition of mine, or non-medical information about me.

Persons/categories of persons receiving the information: Union Security Insurance Company or Union Security Life Insurance Company, and their authorized representatives ("Companies").

I hereby authorize the use or disclosure of my protected health information as described below:

Information to be disclosed: All information necessary to allow the Companies to determine my eligibility for benefits and to process my claim. Such information may include, but not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes (excluding psychotherapy notes), pharmacy records, strength/functional testing, records regarding my Social Security FICA earnings history, Worker's Compensation, State Disability, credit, and earnings and employment history.

The sole purpose of this disclosure is for the adjudication of my claim for insurance benefits under the above-referenced Policy.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Sun Life Financial, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.
- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only - we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be disclosed to or used by the insured member under the above policy.
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non- HIPAA plans.
- This authorization is effective from the date signed below until my claim ends.

_____ _____

SIGNATURE OF CLAIMANT OR LEGAL REPRESENTATIVE | DATE

_____ _____

PRINTED NAME OF LEGAL CLAIMANT REPRESENTATIVE | RELATIONSHIP TO INSURED/MEMBER

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Sun Life Financial®

Part 1 – To be completed by Insured Employee *(Please print or type)*

Full name *(As it appears on your Social Security card.)*			Policy number
Employer name			Employer phone number
This claim is being filed for: ☐ Self ☐ Spouse Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widow			Sex: ☐ Male ☐ Female
Date of birth	Social Security number		Home phone number
address	City	State	Zip
Mobile phone number	E-mail address		

Part 2 – To be completed by spouse if benefits are for spouse *(Please print or type.)*

Full Name (As it appears on your Social Security card.)		Sex: ☐ Male ☐ Female
Date of birth	Social Security number	Mobile phone number

Part 3 – Complete for dependent if benefits are for dependent *(Please print or type.)*

Full name (As it appears on your Social Security card.)			Sex: ☐ Male ☐ Female
Date of birth	Married? ☐ Yes ☐ No	Social Security number	Mobile phone number

If over age 19, but less than 25, full-time student? ☐ Yes ☐ No
If "Yes," attach copy of recent semester grade report.

Name of school		School administration phone
Street address	City	State Zip

If Power of Attorney, Guardian or Conservator, please attach a copy of the document granting that authority and sign below.

Signature _____ Relationship to claimant _____

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Claimant's signature _____ Date _____

Part 4 – Claim Information *(Please print or type. If necessary, attach separate sheet.)*

This ☐ Initial ☐ Recurrent claim

Primary physician name	Phone
Primary physician address	
Hospital name	Phone
Hospital address	
Date when cancer was first diagnosed	

The following checklist can assist you in your submission.

Benefits will be based on the current level of benefits elected. See policy for details.

Level 1 and 2 Items *(Check all that apply.)*

- ☐ Hospital confinement Radiation
- ☐ and chemotherapy In/Out
- ☐ hospital blood and plasma
- ☐ Hospice
- ☐ Extended-care facility In-
- ☐ hospital doctor visits Post-
- ☐ hospital doctor visits
- ☐ Prosthesis
  - ☐ Surgically implanted devices
  - ☐ Other devices
- ☐ Ambulance service
- ☐ Lodging
- ☐ Second surgical opinion
- ☐ Skin cancer
- ☐ Surgery and general anesthesia

Level 2 Items *(Check all that apply.)*

- ☐ First occurrence
- ☐ Alternative Care
  - ☐ Integrative/Education
  - ☐ Palliative Care
  - ☐ Lifestyle Benefit
- ☐ Experimental treatment
- ☐ Medical imaging
- ☐ National Cancer Institute evaluation/consultation
- ☐ Anti-nausea medication
- ☐ Bone marrow transplant
  - ☐ Insured
  - ☐ Donor
- ☐ Stem cell transplant
- ☐ Immunotherapy
- ☐ Home health care
- ☐ Nursing services
- ☐ Transportation
- ☐ Reconstructive surgery
- ☐ Outpatient hospital surgical

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM.

Part 5 – Physician's Statement - ***This statement must be filled in completely by a physician. (Please print or type)***

Date symptoms first appeared	Diagnosis	Date of diagnosis	ICD-9 code

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

If "Yes," please provide diagnosis, the dates of treatment and names of other medical providers.

Provide the name, address and phone number of any referring physicians.

To your knowledge, has your patient used tobacco products in the past 12 months? ☐ Yes ☐ No

Are you the parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the patient: ☐ Yes ☐ No

For services related to a hospitalization, please provide the following. *(Please print or type.)*

Name of hospital

Street address of hospital	City	State	Zip	Phone

Admission date	Discharge date

Physician's Information *(Please print or type.)*

Name	Degree	Specialty/Board Certification

Street address	City	State	Zip

Phone	Fax

Physician's signature	Date

DO NOT PRE-DATE