KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

A **Kemper Health** Company
P.O. Box 3252, Milwaukee, WI 53201-3252
Telephone: 877.851.0890 Fax: 877.721.2343
Website: kemperbenefits.com

CRITICAL ILLNESS CLAIM FORM

Instructions to File a Claim:

- Please complete Insured /Claimant Statement and mail or fax the completed form to the address or fax number indicated above.
- In order to document the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form
- Please have the treating physician complete the Attending Physician Statement. Your physician may mail or fax the completed form to the address or fax number indicated above.
- Please have your physician provide the applicable documents in order to avoid a delay in processing.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy #	Social Security No.	Date of Birth	Sex

Address (Street, City, State, Zip)	Phone Number (With Area Code)

Claimant's Name (Person who is sick)	Date of Birth	Relationship to Insured

Nature of illness	When have you had this same or similar condition?

When did symptoms first appear?	Date first diagnosed?	Date first treated?

Name and address of physician (list all physicians consulted)

Have you been confined to a hospital for this condition? Yes No Admission date: Discharge date:	Please provide name and address of hospital:

Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? Yes or No If yes, when?

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS RESPRESNTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORAMTION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE_____ INSURED'S SIGNATURE: _____

DATE_____ CLAIMANT'S SIGNATURE: _____

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Critical Illness Attending Physician's Statement

(Must be completed by physician. Please complete all applicable questions and provide copies of the supporting reports, medical records, and/ or tests.)

Patient's Full name	Policy or Certificate Number	Date of Birth

Diagnosis? (Please use ICD 9 codes)	When did symptoms first appear?	When did the patient first consult you for this condition?

CANCER/ CANCER IN SITU

Please circle if cancer was pathology diagnosed or clinically diagnosed.

Date of Diagnosis:_____

Has the patient ever had the same or similar condition? YES NO

(If Cancer/ Cancer In Situ was pathologically diagnosed, please attach a copy of the pathology report. If the Cancer/ Cancer In Situ was clinically diagnosed, please provide the reasons that pathological diagnosis was not obtained and attach medical documentation that supports the diagnosis of Cancer.)

COMA

Has the patient been in a continuous state of profound unconsciousness for at least 14 days? YES NO

Has the patient required intubation for respiratory assistance? YES NO

(Please attach copies of clinical diagnosis)

CORONARY ARTERY BYPASS SURGERY/ ANGIOPLASTY

Type of Surgery: _____ Date of Surgery:_____

(Please provide surgical report)

END-STAGE RENAL FAILURE

Has there been chronic, irreversible failure of the function of both kidneys? YES NO

Has the patient undergone peritoneal dialysis on a weekly basis? YES NO

(Please attach copies of medical records documenting end stage renal failure and frequency of dialysis.)

HEART ATTACK

Has the patient shown an elevation of cardiac enzymes? YES NO

Were there associated new electrocardiographic (EKG) changes consistent with injury? YES NO

Were there confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms? YES NO

(Please attach copies of EKG, lab results, and other diagnostic test results.)

MAJOR HUMAN ORGAN TRANSPLANT SURGERY

Has the patient been the recipient of a human-to-human transplant of a heart, lung, liver, heart-lung, kidney, or pancreas? YES NO

Date of surgery:_____ (Please attach copy of operative report.)

MAJOR THIRD DEGREE BURNS

Does the tissue damage in which there is destruction of the entire epidermis and underlying dermis cover more that 10% of total body surface area? YES NO

(Please provide clinical documentation indicating total body surface area.)

OCCUPATIONAL HIV

Has the patient undergone a blood test within 5 days of the accident that indicates the absence of HIV or antibodies of the HIV Virus? YES NO

Has the patient undergone further blood tests within 12 months that indicates the presence of HIV or antibodies of the HIV Virus? YES NO

(Please provide clinical diagnosis.)

PARALYSIS/ ALZHEIMER'S DISEASE/ PARKINSON'S DISEASE/ MUSCULAR DYSTROPHY/ BENIGN BRAIN TUMOR/ BONE MARROW TRANSPLANT/ LOSS OF SIGHT, SPEECH OR HEARING

Date of Diagnosis:_____

(Please provide clinical documentation)

STROKE

Has a cerebrovascular event occur resulting in permanent, neurological impairment and resulted in paralysis or other measurable objective neurological defect persisting for at least 30 days? YES NO

Have there been documented neurological deficits? YES NO

Have there been confirmatory neuron-imaging studies? YES NO

(Please attach copies of all documented neurological deficits and confirmatory neuron-imaging studies.)

Physician's Name (please print):	Degree:	Phone No.

Signature:	Fax No.

Address: Street, City, State, Zip	Tax identification No.

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Critical Illness Wellness Claim

Instructions to File a Claim:

- Please complete Insured/Claimant Statement and mail or fax the completed form to the address or fax number indicated above.
- In order to document the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please attach a copy of itemized bill indicating: patient name, date of service, name of provider, type of service, and diagnosis code.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/ Certificate #	Social Security No.	Date of Birth	Sex

Address (Street, City, State, Zip)	Phone Number (With Area Code)

Claimant's Name	Date of Birth	Relationship to Insured

Please circle the appropriate wellness screening and provide itemized bill.

Abdominal aortic aneurysm ultrasound	Fasting blood glucose test
Blood test for triglycerides	Flexible sigmoidoscopy
Bone marrow testing	Hemoccult stool analysis
Breast ultrasound	Mammography
CA 15-3 (blood test for breast cancer)	Pap Smear
CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)
Carotid ultrasound	Serum cholesterol HDL/LDL
CEA (blood test for colon cancer)	Serum protein electrophoresis (blood test for myeloma)
Chest x-ray	Stress Test
Colonoscopy	Thermography
CT Angiography	Annual physical examinations
EKG	Immunizations
Double contrast barium enema	

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