

KEMPER Health

INSURANCE BENEFITS PROVIDED BY RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988

Austin, TX 78766-9988

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CRITICAL ILLNESS WELLNESS CLAIM FORM

Instructions to File a Claim:

- Please complete Insured/Claimant Statement. You may also mail, email, or fax the completed form.
- 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 click 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 examination		
EKG		Immunizations		
Double contrast barium enema				

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN 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 REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION 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 AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. 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: _____