COLONIAL
LIFE & ACCIDENT INSURANCE COMPANY
A UNUM® Company
The Leader in Payroll Marketing®

Home Office: P. O. Box 100195, Columbia, South Carolina 29202-3195

Claim Form and Instructions

To ensure smooth processing of your claim, please read the instructions carefully and complete all required information.

When you chose Colonial, you chose a financially strong company with more than 50 years of experience and an ongoing commitment to quality customer service. You can count on us to deliver what we promise.

Things You Should Know!

- By calling 1-800-325-4368, you can obtain general information on your claim twenty-four hours a day, seven days a week. Please allow us 48 hours to update our system on Faxed claims.
- You can FAX us your claim at 1-800-880-9325. Faxing your claims means your claim will be received three to five days faster.
- For Pregnancy and Wellness claims, ONLY complete the Express Filing forms on pages 7 and 8.
- Wellness Claims can even be called in to 1-800-325-4368 rather than filing by mail. All we need is your wellness test, date of treatment, treating physician, and physician's phone number. We will call to verify the test and mail your benefit payment, often the same day.

Mail claim form and enclosures directly to:

Colonial Life & Accident Insurance Company
Post Office Box 100195
Columbia, South Carolina 29202-3195

OR

Fax claim form and enclosures directly to:

1-800-880-9325 (limit 20 pages)

Refer to your *Service Guide for Colonial Policyholders* for additional information.

Want Fast Claims Service? Follow these TIPS Closely!

- Please do not use highlighter on the claim form if faxing. (It is not necessary to mail originals if you use fax mail box.)
- Most claims take longer when information is missing. Follow the chart below and complete all information.
- Page 6 of the claim form is for you and your doctor to complete. Just attaching a doctor's bill may not be enough to have your claim paid. We must have a diagnosis from your doctor. Missing Patient Social Security Number can delay processing your claim.
- Please complete Section F and sign your authorization. Without your signature, we will not be able to process your claim.
- If you are filing for disability benefits, please notify us of any changes in your condition and/or treatment. We will advise you if additional claim form(s) are needed. Please notify us when you return to work.
- Your policy may include a first year pre-existing condition exclusion. If so, we may need additional medical information to process your claim. To speed the process, please provide detailed medical information in Section D and have your doctor complete Question 4 on page 5.
- Attach all doctor and hospital bills or FAX them with your claim form.
- If you sign Line 13 on page 6, Colonial will pay all benefits to the doctor or hospital listed. Make sure this is what you want us to do!

Please refer to this chart for the sections you need to complete on your claim form.
Your medical provider is to complete pages 5 and 6.

Policy Type	Section A	Section B	Section C	Section D	Section E	Section F	Express Filing	Attachments*
Accident	✔	✔		✔	✔	✔		Detailed itemized bills
Sickness	✔		✔	✔	✔	✔		Detailed itemized bills
Hospital Income	✔		✔	✔	✔	✔		Detailed itemized bills
Cancer	✔		✔	✔	✔	✔		Pathology Report and itemized bills
Intensive Care	✔		✔	✔		✔		Detailed itemized bills
Wellness							✔	Detailed itemized bills
Pregnancy Claim							✔	

***NOTE: Section E should be only completed if you are filing for DISABILITY benefits.
A diagnosis is required from your doctor or medical facility for all claims.

Mail to: Colonial Life & Accident Insurance Company
P. O. Box 100195
Columbia, South Carolina 29202-3195
1-800-325-4368

SIDE 1

PLEASE PRINT

OR FAX MAIL BOX: 1-800-880-9325

SECTION A

Policyholder Information		Patient Information (Check one) ❑ Spouse ❑ Dependent ❑ Self
Social Security Number *IMPORTANT* — —	Birthdate (mm/dd/yyyy) / /	Social Security Number *IMPORTANT* — — Birthdate (mm/dd/yyyy) / /
Name (First, Middle, Last)	❑ Male ❑ Female	Name (First, Middle, Last) ❑ Male ❑ Female
Address (Street) ❑ Check here if NEW address	Apt #	Address (Street) ❑ Check here if NEW address Apt #
City State	Zip Code	City State Zip Code
Policy Numbers (if known)		Home phone number ( ) Work phone number ( ) ext.
Home phone number ( ) Work phone number ( )	ext.	Is dependent a full-time student? ❑ Yes ❑ No AGE ____

This Claim is for: ❑ Accident ❑ Wellness ❑ Intensive Care ❑ Hospital Income ❑ Other
❑ Sickness ❑ Cancer (If claim is being filed for cancer, enclose pathology report.)

SECTION B IF ACCIDENTAL INJURY

Date (mm dd/yyyy) you were injured: Time of accident:	Where did it happen?
_____ ❑ AM ❑ PM	
How did it happen?	
Did your injuries occur while you were working for pay or profit? ❑ Yes (on-job) ❑ No (off-job)	Have you received treatment, medication or advice from a doctor in the past for this or a similar condition? ❑ Yes ❑ No If yes, date (mm/dd/yyyy) last seen: _____
Dates (mm.dd/yyyy) unable to work: FROM TO	If sports injury, what type (i.e., high school, junior high, etc.):

SECTION C IF SICKNESS/ILLNESS/CANCER/INTENSIVE CARE/HOSPITAL INCOME/OTHER

What type of illness are you claiming?	When were you first treated for this illness? (Date mm/dd/yyyy)
Have you ever had the same or similar condition in the past? ❑ YES ❑ NO	If yes, please complete the MEDICAL information in Section D
Were you unable to work due to this illness in the last six months to a year? ❑ YES ❑ NO If yes, please explain:	Dates (mm/dd/yyyy) unable to work: FROM TO

CLAIM FORM CONTINUED – REVERSE SIDE

SECTION D YOUR MEDICAL INFORMATION (Please attach a separate sheet if additional space is needed)

Primary Doctor	Treating Doctor	Referring Doctor
Name	Name	Name
Address (Street)	Address (Street)	Address (Street)
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Telephone Number ( )	Telephone Number ( )	Telephone Number ( )

HOSPITAL INFORMATION (If ever hospitalized or seen at the hospital)

Hospital Name	Hospital Name	Hospital Name
Address	Address	Address
Telephone Number ( )	Telephone Number ( )	Telephone Number ( )
Date Seen/Admitted	Date Seen/Admitted	Date Seen/Admitted
Date Discharged	Date Discharged	Date Discharged

SECTION E EMPLOYER SECTION (to be completed by an authorized person at your place of employment)

Name of Employer

Telephone Number ( )

Billing Control Number

Dates (mm/dd/yyyy) employee unable to work
FROM: ❑ AM ❑ PM TO: ❑ AM ❑ PM

Date (mm/dd/yyyy) employee returned to his/her main or principal duties:
Returned part-time Returned full-time Light duty

Is Workers' Compensation being filed for? ❑ Yes ❑ No

Did the accident occur while working for wage or profit? ❑ Yes (on-job) ❑ No (off-job)

Employee Job Title _____

Employee's job title duties include:

Lifting	❑ less than 15 lbs.	❑ 15 to 44 lbs.	❑ over 45 lbs.
Stooping/bending	❑ none	❑ seldom	❑ frequent
Crawling/climbing kneeling	❑ none	❑ seldom	❑ frequent
Reaching/pulling pushing	❑ none	❑ seldom	❑ frequent
Repetitive	❑ none	❑ seldom	❑ frequent
Management duties	❑ none	❑ seldom	❑ frequent

Sitting (Number of hours each day). _____
Standing/Walking (hours each day): _____

Signed | Title | Date (mm/dd/yyyy)

SECTION F

For your protection, California and other states' law requires the following to appear on this form: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this claim form may also constitute a crime under federal laws. We will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate. (Florida - Felony of the third degree)

AUTHORIZATION POLICYHOLDER'S NAME (print) _____ SOCIAL SECURITY NUMBER _____

I have checked the above answers and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I hereby authorize any medical practitioner or facility, psychologist, social worker, hospital, clinic, including the Veterans Administration, insurance or reinsuring company, consumer reporting agency, employer, the Social Security Administration, Medical Information Bureau, Inc., insurance support organization, or other organization or person having medical and non-medical information or knowledge of me or my minor children, to give to Colonial Life & Accident Insurance Company, hereinafter called the Company, or its authorized representative any and all information. This Authorization shall include information concerning alcohol or drug abuse, mental health, AIDS or AIDS-related conditions. I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance or eligibility for benefits under an existing policy. I authorize the Company to release any such information to reinsuring companies, the Medical Information Bureau, Inc., persons or organization performing business, legal, medical or insurance services related to me or my minor children insurance or claim under that insurance, or any other public or private entity as may be lawfully required. I understand that I may receive a copy of this Authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for the duration of my claim not to exceed two and one-half years from the date shown below.

DATE (mm/dd/yyyy) PATIENT SIGNATURE POLICYHOLDER SIGNATURE

To be answered by your medical provider:

1. If surgery has been performed, please attach a copy of the operative report.

2. If due to Cancer, please enclose a Pathology Report.

3. If due to an accident, please provide complete information, date and description.

_____

_____

_____

4. Has this patient been treated for this same or similar condition in the past, prior to this occurrence? If so, please list the diagnosis and the dates of treatment.

_____

_____

_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS REGARDING YOUR PATIENT'S STATUS:

1. Is your patient able to work? ❑ Yes ❑ No If No, what medical restrictions or limitations have been placed on this patient preventing his/her return to work?

_____

_____

_____ Expected return to work date (mm/dd/yyyy): _____

2. If multiple conditions exist, what is the primary disabling condition?

_____

_____

3. Nature of treatment/treatment plan (including surgery and medication prescribed, if any).

_____

_____

_____

_____ _____

Medical Provider's Signature Date (mm/dd/yyyy)

OVER

PLEASE DO NOT STAPLE IN THIS AREA

Colonial Life & Accident Insurance Company
P. O. Box 100195
Columbia, South Carolina 29202-3195

SIDE 2
Medical Provider
To Complete

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP Health Plan ☐ (SSN or ID) FECA BLK Lung ☐ (SSN) OTHER ☐ (ID)

1A. INSURED'S ID NUMBER (For program in item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S DATE OF BIRTH MM DD YYYY Sex M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

City State

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-time Student ☐ Part-Time Student ☐

City State

Zip Code Telephone (include Area Code) ( )

Zip Code Telephone (include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. Other Insured's Policy or Group Number

a. Employment:? (Current or Previous) Yes ☐ No ☐

a. Insured's Date of Birth MM DD YYYY Sex M ☐ F ☐

b. Other Insured's Date of Birth MM DD YYYY Sex M ☐ F ☐

b. Auto Accident? Yes ☐ No ☐ Place (State)

b. Employer's Name or School Name

c. Employer's Name or School Name

c. Other Accident? Yes ☐ No ☐

c. Insurance Plan Name or Program Name

d. Insurance Plan Name or Program Name

10d. Reserved For Local Use

d. Is There Another Health Benefit Plan? Yes ☐ No ☐ *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed Date (mm/dd/yyyy)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed

14. DATE OF CURRENT: MM DD YYYY ILLNESS (First symptom) or INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. Give First Date MM DD YYYY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YYYY From MM DD YYYY To

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17A. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YYYY From MM DD YYYY To

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? Yes ☐ No ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (Relate items 1, 2, 3 or 4 to item 24E by line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION Code Original Ref. No.

23. Prior Authorization Number

PHYSICIAN OR SUPPLIER INFORMATION

24. A Date(s) of Service From MM DD YYYY	To MM DD YYYY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved For Local Use
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. Claims, see back) Yes ☐ No ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signed Date (mm/dd/yyyy)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & Phone #.

PIN# GRP#

PLEASE PRINT OR TYPE

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P. O. Box 100195
Columbia, SC 29202-3195

Please complete the section that applies to you.
Please Allow Two Weeks after Mailing your Claim for us to Process.

Express Filing for Pregnancy Claim

This is for normal recovery period only. If you are totally disabled prior to delivery or beyond 6 weeks for vaginal delivery and 8 weeks for C-section delivery, please complete a claim form for disability.

	Policy Number (If known)		Phone Number
1. Policyholder Name (First, Middle, Last)		Social Security Number	Birthdate (mm/dd/yyyy)
2. Address (Street)	(City)	(State)	(Zip Code)
3. Patient's name:		Patient's Social Security #	
4. Delivery Date (mm/dd/yyyy): ❑ Vaginal ❑ C-section		First Date (mm/dd/yyyy) of Treatment Including Any Phone Consultations	
5. Doctor's Signature		Date (mm/dd/yyyy)	Tax Identification Number
6. Doctor's Name & Address (Please Print)			Phone Number
7. Referring Physician's Name & Address			
8. Hospital Name			Dates of Hospital Confinement
9. Hospital Address			Phone Number

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I have checked the above answers and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I hereby authorize any medical practitioner or facility, psychologist, social worker, hospital, clinic, including the Veterans Administration, insurance or reinsuring company, consumer reporting agency, employer, the Social Security Administration, Medical Information Bureau, Inc., insurance support organization, or other organization or person having medical and non-medical information or knowledge of me or my minor children, to give to Colonial Life & Accident Insurance Company, hereinafter called the Company, or its authorized representative any and all information. This Authorization shall include information concerning alcohol or drug abuse, mental health, AIDS or AIDS-related conditions. I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance or eligibility for benefits under an existing policy. I authorize the Company to release any such information to reinsuring companies, the Medical Information Bureau, Inc., persons or organization performing business, legal, medical or insurance services related to me or my minor children insurance or claim under that insurance, or any other public or private entity as may be lawfully required. I understand that I may receive a copy of this Authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for the duration of my claim not to exceed two and one-half years from the date shown below.

DATE (mm/dd/yyyy) _____ POLICYHOLDER SIGNATURE _____ PATIENT SIGNATURE _____

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Please complete the section that applies to you.
Please Allow Two Weeks after Mailing your Claim for us to Process.

Express Filing for Cancer Screening Wellness Benefit

(Please Refer to Your Cancer Policy for the Specific Tests that are Covered.)

For Express Service You Must Send the Following Information from your Doctor.

- **The type of cancer wellness screening that was performed, date of service, and copy of bill.**
- **If you are treated at a non-cost incurred facility, please furnish verification from the facility of the date and type of test performed.**

1. Patient Name (First, Middle, Last)	❑ Spouse ❑ Child	❑ Male ❑ Female	Patient Social Security Number
Birthdate (mm/dd/yyyy)	Phone Number	Policy Number (If known)	
2. Type of Test Performed			Date Test Performed (mm/dd/yyyy)
3. Doctor's Name & Address			Doctor's Phone #
4. Policyholder Name (First, Middle, Last)	❑ Male ❑ Female	Social Security Number	Birthdate (mm/dd/yyyy)
5. Address (Street) (City)	(State)	(Zip Code)	

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DATE (mm/dd/yyyy) _____ POLICYHOLDER SIGNATURE _____ PATIENT SIGNATURE _____

Filing for Transportation (For Cancer Policies Only)

***** FOR INTERNAL CANCER ONLY – Please Refer to your Cancer Policy to see if the Transportation Benefit is applicable *****

Patient Name _____ Policy Number (If known) _____ Patient Social Security Number _____

Date (mm/dd/yyyy)	**Mileage**	**From (City)**	**To (City)**

Please attach verification of treatment dates from your doctor's office.

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