CRITICAL ILLNESS INSTRUCTIONS FOR FILING CLAIMS

Dear Policyholder:

Thank you for choosing USAble Life to provide your critical illness protection. We have included these instructions to assist you in the event you need to file a claim. You can obtain claim and authorization to release medical forms from our website at www.usablelife.com or contact a Personal Account Representative at the phone number listed below. **Please remember claims must be received within 90 days from the date of diagnosis of a covered critical illness, or the date of a covered wellness exam.**

CRITICAL ILLNESS CLAIMS

1. Complete and sign the Insured's Statement on the Critical Illness claim form for the specific diagnosed illness.
2. Answer **ALL** questions, or state "not applicable".
3. Have your physician complete the Attending Physician's Statement. Be sure **ALL** questions are answered and the form is signed.
4. Sign and return the Authorization for Release of Medical Records and Fraud Notice forms.

Important Note: Complete the Insured and Attending Physician's Statements for the diagnosed critical illness only.

WELLNESS BENEFITS

1. Please mail us an ITEMIZED bill for the covered test or service. Payment will be mailed to the address on the bill. Please make sure this address is correct. (Do not rely on your physician or hospital to file your claim.) You can also obtain instructions on how to file wellness claims on our website.
2. You do NOT need a claim form or Authorization to Release Medical Records form to collect reimbursement for these benefits BUT the following information must be submitted:
   - Insured's Name and Social Security Number
   - Policy Number (very important)
   - Patient's Name, Date of Birth, and Social Security Number
   - Date of Service
   - Current mailing address

   You may write the above on the itemized bill for submission.
3. Incomplete claims cannot be processed and will be returned to you.

Mail Claim Forms and Bills To:
Claim Department
USAble Life
P.O. Box 1650
Little Rock, AR 72203-1650
Life and Health Claim Fax: (501) 235-8416
Wellness Claim Fax: (501) 235-8400
Email: claims@usablelife.com

For Questions or Assistance Contact:
Customer Service Representative
USAble Life
1-800-370-5856
8:00 a.m. - 4:30 p.m. Central Time
Email: custserv@usablelife.com

Warning: *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.*

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8416
E-mail: claims@usablelife.com

Insured's Statement
Coronary Artery Bypass Graft (CABG)

For H.O. Use Only	
Eff	
PTD	
Benefits	

Instructions

1. **Please type or print in blue or black ink.**
2. **Insured's signature must be signed and currently dated.**
3. **Fax or mail the completed form to USAble Life.**

INSURED'S STATEMENT

Patient's Full Name (Last, First)	Social Security Number	Date of Birth

Home Address (City, State, Zip)

1. How long have you been under a physician's care?
2. On what date did you first consult a physician which precipitated the need for a CABG?
3. When did symptoms first appear for this condition?
4. Have you previously had a coronary angioplasty or bypass graft? ☐ Yes ☐ No If yes, what were the date(s) and reason(s)?
5. What was the reason for receiving the CABG?
6. On what date was the CABG performed?
7. For which conditions have you been treated in the last 5 years? Provide diagnosis and diagnosis date.
8. First doctor seen:

Physician Name and Practice				Specialty
Address	City	State	Zip	Telephone

9. Names and addresses of all doctors and hospitals consulted for ***this*** condition (use separate sheet if necessary):

Physician	Address, City , State and Zip

10. Names and addresses of all doctors seen for ***any*** condition in the past five years (use separate sheet if necessary):

Physician	Address, City , State and Zip	Condition

PATIENT'S SIGNATURE

I attest to the fact that the information I have provided above is to the best of my knowledge, complete and accurate.

Patient's Signature	Date
Patient's Name	Telephone

Anyone who commits with the purpose to injure, defraud or deceive USAble Life, knowingly submits or helps someone else to submit any oral or written statements knowing that these statements contain false incomplete, or misleading information concerning any application, claims for payment, or benefits pursuant to this insurance policy is committing insurance fraud. USAble Life will pursue such activity to the fullest extent allowable by law.

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8416
E-mail: claims@usablelife.com

Attending Physician's Statement Coronary Artery Bypass Graft (CABG)

For H.O. Use Only	
Eff	
PTD	
Benefits	

Instructions

1. **Please type or print in blue or black ink.**
2. **Physician Signature must be signed and currently dated.**
3. **Fax or mail the completed form to USAble Life.**

GENERAL INFORMATION

Covered Person's Full Name (Last, First)	Social Security Number	Date of Birth

The above named insured has filed a claim for benefits due to CABG. The insured has given us authorization (see attached) to obtain information needed to assess the claim. Please answer the questions below and return the form to us, along with the supporting clinical documentation.

1. How long has the patient been under your care?
2. On what date were you first consulted for the condition which precipitated the need for a CABG?
3. When did symptoms first appear for this condition?
4. When was the patient first advised of his/her need for a CABG?
5. Has the patient previously had a coronary angioplasty or bypass graft? ☐ Yes ☐ No If yes, what were the date(s) and reason(s)?
6. What was the reason for performing the CABG?
7. What clinical symptoms were present at the time of evaluation?
8. On what date was the CABG performed?
9. Has there been past evidence of hypertension, angina pectoris, circulatory disorders, stroke, chest pain on exertion, diabetes mellitus, cardiac arrhythmia, coronary artery disease, abnormal EKGs, hyperlipidemia or obesity? ☐ Yes ☐ No If yes, please give dates or consultations(s) and diagnosis(es).
10. For which conditions have you treated this patient in the last 5 years? Provide diagnosis and diagnosis date.

PHYSICIAN'S INFORMATION

1. Was the patient referred to you by another physician? ☐ Yes ☐ No If yes, please provide contact information.

Physician Name and Practice		Specialty		
Address	City	State	Zip	Telephone

2. Has this patient been hospitalized for this condition? ☐ Yes ☐ No If yes, please provide contact information.

Hospital Name		Specialty		
Address	City	State	Zip	Telephone

Covered Person's Full Name (Last, First)	Social Security Number	Date of Birth

SUPPORTING DOCUMENTATION

1. Office notes from the past five years have been attached? ☐ Yes ☐ No If No, where could these records be obtained?

2. Hospital and/or surgical notes have been attached? ☐ Yes ☐ No If No, where could these records be obtained?

3. Imaging studies have been attached? ☐ Yes ☐ No If No, where could these records be obtained?

PHYSICIAN'S SIGNATURE

I attest to the fact that the information I have provided above is to the best of my knowledge, complete and accurate.

Physician's Signature	Date
Physician's Name	Telephone
Physician's Address (Include Street, City, State and Zip)	Fax

Anyone who commits with the purpose to injure, defraud or deceive USAble Life, knowingly submits or helps someone else to submit any oral or written statements knowing that these statements contain false incomplete, or misleading information concerning any application, claims for payment, or benefits pursuant to this insurance policy is committing insurance fraud. USAble Life will pursue such activity to the fullest extent allowable by law.

AUTHORIZATION | To Disclose, Obtain and Use Personal Information

Read and sign below.

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the MIB, Inc., benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

Signature

Sign and date this form.

I have executed this authorization intending that it will be effective on and after:

Date

•

Signature

•

Printed name

•

Return original with your claim and retain a copy of this authorization and claim form for your records.

USABLE® LIFE | FRAUD NOTICE

FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE:
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. Please see below for special notices required by state law.

AL Residents Only: 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.

AK Residents Only: Any 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.

AZ Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: 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.

CO Residents Only: 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.

DE, ID, IN, OK Residents Only: 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.

DC Residents Only: 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.

FL Residents Only: 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 of the third degree.

KS Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.

KY Residents Only: 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.

ME and TN Residents Only: 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 and denial of insurance benefits.

MD, RI, TX Residents Only: 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.

MN Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH Residents Only: 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.

NJ Residents Only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OH Residents Only: Any person who, with the 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.

OR Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison.

PA Residents Only: 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.

VT Resident Only: 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.

VA and WA Residents Only: 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.

SIGN AND DATE BELOW

I have read and understand the Fraud Warning that applies to my state of residence.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE