Critical Illness Claim Form

Please read and follow these instructions should there be a need to file a claim for a covered illness.

- The claim form must be completed and signed by the insured (or parent/guardian in the event of a dependent child).
- Please make sure the policy number is on the claim form.
- The “Authorization for Use and Disclosure of Information” must be signed, dated, and included with your submission.

Processing delays may result if we are not provided the above information

- Return the completed form and signed authorization to:
  
  **Medico Insurance Company**
  
P.O. Box 10386
  
  Des Moines, IA  50306-0386

- One claim form needs to be completed when the insured has been diagnosed with a critical illness.
- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

If you have any questions, please contact our Customer Care Center.

**800-228-6080**
Critical Illness Claim Form - Insured/Patient Information

Section A
Insured/Patient Name __________________________ Date of Birth __________ / ______ / ______
Address __________________________________________ Street __________ City __________ State ______ ZIP ______
Telephone Number __________________________ Policy Number __________________________

Section B
Diagnosed Condition __________________________ Date of Diagnosis __________ / ______ / ______
Has the insured been diagnosed with this condition before? ☐ Yes ☐ No
If Yes, please list the date first diagnosed: __________________________________________
List the names, addresses, and telephone numbers of the physicians treating you for this condition. Attach a separate sheet of paper if additional space is needed.

Physician’s Name __________________________
Address __________________________________________ Street __________ City __________ State ______ ZIP ______
Telephone Number __________________________

Physician’s Name __________________________
Address __________________________________________ Street __________ City __________ State ______ ZIP ______
Telephone Number __________________________

Section C
If Insured has been hospitalized, complete the following:

<table>
<thead>
<tr>
<th>Date of Confinement</th>
<th>Hospital</th>
<th>Address/Telephone</th>
<th>Diagnosis</th>
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</thead>
<tbody>
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</tbody>
</table>
I understand that this information will be used by Medico Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Insured Signature_______________________________________________________ Date __________ / __________ / __________

Print Name ___________________________________________________________________________________________
Critical Illness Claim Form - Physician Statement

To be completed by the Attending Physician providing care for this condition (PLEASE PRINT)

Diagnosis of Cancer

Diagnosis __________________________________________________________

Date of Diagnosis  __________________________________________________________________________________________

Diagnostic Codes  __________________________________________________________________________________________

Is metastatic disease present?        ☐ Yes        ☐ No

Please describe  ____________________________________________________________________________________________

___________________________________________________________________________________________________________

Please include a copy of diagnostic test results or operative pathology result reports that support this diagnosis. If no supporting pathology report exists, please provide documentation of diagnosis, supporting information and current plan of treatment.

Has patient ever had same or similar symptoms/conditions?        ☐ Yes        ☐ No

If Yes, please provide the date of other conditions and symptoms  ________________________________________________

I certify that the above information is complete and accurate to the best of my knowledge.

______________________________________________________________________________   ______________________________________

Signature of Physician Date

______________________________________________________________________________  ______________________________________

Printed Name Telephone Number

To be completed by the Attending Physician providing care for this condition (PLEASE PRINT)
Critical Illness Claim Form - Physician Statement

To be completed by the Attending Physician providing care for this condition (PLEASE PRINT)

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Diagnosis of Myocardial Infarction (Heart Attack)

Diagnosis

Date of Diagnosis / / 

Diagnostic Codes

Electrocardiogram Evaluation (Please include a copy of the EKG report)

EKG done? ☐ Yes ☐ No Date: / / / 

Cardiac Enzyme Evaluation (Please include a copy of the cardiac enzyme report)

Evaluation done? ☐ Yes ☐ No Date: / / / 

Has patient ever had same or similar symptoms/conditions? ☐ Yes ☐ No

If Yes, please provide the date of other conditions and symptoms / / / 

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I certify that the above information is complete and accurate to the best of my knowledge.

/ / 

Signature of Physician Date

( ) 

Printed Name Telephone Number
Diagnosis of Cerebro-Vascular Accident or ‘Stroke’

When did symptoms first appear? __________ / _______ / ________

Date of Diagnosis __________ / _______ / ________

Diagnostic Codes ________________________________________________

Were neuro-imaging studies done?  ☐ Yes  ☐ No

If Yes, please include a copy of the diagnostic imaging results.

Please describe neurological deficits ________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Have neurological deficits been present for at least 48 hours following the occurrence of the stroke?  ☐ Yes  ☐ No

Has patient ever had same or similar symptoms/conditions?  ☐ Yes  ☐ No

If Yes, please provide the date of other conditions and symptoms _________ / _______ / ________

I certify that the above information is complete and accurate to the best of my knowledge.

__________________________________________________________________________________

Signature of Physician ___________________________ Date _________ / _______ / ________

Printed Name ___________________________ Telephone Number (_________)
### FRAUD WARNING STATEMENT

<table>
<thead>
<tr>
<th>State</th>
<th>Statement</th>
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</thead>
<tbody>
<tr>
<td><strong>Alabama</strong></td>
<td>Any person who knowingly presents 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.</td>
</tr>
<tr>
<td><strong>Arkansas, Louisiana, and West Virginia</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Colorado</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Florida</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Kansas</strong></td>
<td>Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law.</td>
</tr>
<tr>
<td><strong>Kentucky</strong></td>
<td>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.</td>
</tr>
<tr>
<td><strong>Maine, Tennessee, Virginia, and Washington</strong></td>
<td>It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.</td>
</tr>
<tr>
<td><strong>New Mexico</strong></td>
<td>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 criminal penalties.</td>
</tr>
<tr>
<td><strong>Ohio</strong></td>
<td>Any person who, with intent to defraud or knowing that he or she 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.</td>
</tr>
<tr>
<td><strong>Oklahoma</strong></td>
<td>Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.</td>
</tr>
<tr>
<td><strong>Oregon</strong></td>
<td>Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud may be a violation of federal law.</td>
</tr>
<tr>
<td><strong>Pennsylvania</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Residents of All Other States</strong></td>
<td>NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.</td>
</tr>
</tbody>
</table>

The furnishing of forms does not constitute an admission of liability on the part of the Company.
Authorization for the Use and Disclosure of Medical Information

I hereby authorize Medico® Insurance Company to use and/or disclose the following information about me as described below. I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.

Policy Number: _________________________________________  ____ / ____ / ____  

Date of Birth

Full name of insured whose information is being requested for use/disclosure

1. Persons/class of persons authorized to use or make disclosure of the information: Any health care providers from whom you sought treatment or received consultation.

2. Name and address of persons/class of persons authorized to receive the information: Medico Insurance Company staff with appropriate access clearance to use and disclose the applicable information.

3. Specific description of information that may be used/disclosed:
   - Medical Information (such examples may include, but is not limited to, the following: Explanation of Benefits, medical records, dates of services, amounts payable, health care provider information, services rendered, claim information, etc.)
   - Other, please specify: _______________________________________________________________________

4. The information will be used/disclosed for the following purposes (all purposes must be listed and described):
   - Benefit/Payment Purposes (examples include, but are not limited to, the following: for processing my claims and servicing my coverage, explanation of benefits, assessment of coverage needs)
   - Other, please specify: _______________________________________________________________________

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand as a consequence of my failure to sign this authorization, Medico Insurance Company may not be able to process my claim for insurance benefits, resulting in a claim denial. I understand that Medico Insurance Company requires the information sought through this authorization to determine claim eligibility under the policy contract.

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© 2017 Medico Insurance Company
6. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
   a. Medico Insurance Company or another third party has taken action in reliance on this authorization; or
   b. this authorization is obtained as a condition for obtaining insurance coverage, other law may provide Medico Insurance Company with the right to contest a claim under the policy or the policy itself.
I understand to revoke my authorization I should send my written revocation request to:

Medico Insurance Company
P. O. Box 21660
Eagan, MN 55121-0660
Fax: 402-496-8199

7. This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date of signature.

If you are signing as a personal representative for the policyholder, please read and sign below.

I, ________________________________, hereby certify and attest that I am the duly authorized personal representative of ________________________________, that my relationship to the policyholder is ________________________________, and that I have the lawful authority to enter into this authorization on behalf of the policyholder. I have read the provisions set forth in this authorization, and agree that Medico Insurance Company may use and/or disclose the aforementioned information for the purposes set forth herein.

________________________________________  ________________
Signature of Individual or Personal Representative* Date

________________________________________  ______________________
Printed Name of Individual or Personal Representative* Relationship of Personal Representative or Authority to Act for the Individual*

You will be provided a copy of this signed Authorization.