BlueCross BlueShield of Illinois

Critical Illness Claim Form

Phone Number: (800) 367-6401

Return to Blue Cross and Blue Shield of Illinois P.O. Box 7070 Downers Grove, IL 60515 Attn: Claims Department or Fax to: (855) 645-8242 or Email to: groupsupplementalClaimsIL@BCBSIL.com

EMPLOYEE SECTION	Employer/Group Name:	Group No.:	Group Contact:
Employee's Name:			Date of Birth:
Social Security No.:	Gender: ☐ Male ☐ Female	Mailing Address:	
Email Address:		Preferred Telephone Number:	

DEPENDENT SECTION	**COMPLETE THIS SECTION IF THE CLAIM IS FOR A DEPENDENT** ☐ Spouse ☐ Child	
Dependent's Name:	Social Security No.:	Gender: ☐ Male ☐ Female
Date of Birth:	Dependent's Preferred Telephone Number:	

CLAIM INFORMATION SECTION

Please list the condition for which you are claiming a benefit (see conditions below)

On what date did the symptoms first appear:

Has the insured person ever had the same or similar condition in the past: ☐ Yes ☐ No Dates of prior treatment: _____

If yes, please provide names, addresses, telephone, and fax numbers of physicians who previously treated the patient:

_____

_____

Please indicate name of hospital & dates of hospitalization, if applicable:

Name of hospital: _____ Admitted: _____ Discharged: _____

Please indicate name, address and telephone number of current physician treating the insured person for this condition:

_____

PLEASE CHECK CONDITION FOR WHICH YOU ARE CLAIMING A BENEFIT. Not all benefits may be available under your plan. Please refer to your certificate of coverage.
IMPORTANT: PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, TEST RESULTS, ADMIT/DISCHARGE SUMMARIES, AND OPERATIVE REPORT.

CONDITIONS

- ☐ Benign Brain Tumor
- ☐ Carcinoma in situ
- ☐ Coma due to Severe Traumatic Brain Injury
- ☐ Coronary Angioplasty
- ☐ End Stage Renal Failure
- ☐ Heart Attack
- ☐ Invasive Cancer
- ☐ Loss of Limb
- ☐ Loss of Sight, Speech, or Hearing
- ☐ Major Burns
- ☐ Major Heart Surgery
- ☐ Major Organ Failure
- ☐ Occupational HIV
- ☐ Paralysis
- ☐ Severe COVID-19 Infection
- ☐ Skin Cancer
- ☐ Stroke

Neurological Conditions:

- ☐ Advanced Alzheimer's Disease
- ☐ Advanced Multiple Sclerosis
- ☐ Advanced Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)

Childhood Conditions:

- ☐ Cerebral Palsy
- ☐ Cleft Lip or Palate
- ☐ Cystic Fibrosis
- ☐ Down Syndrome
- ☐ Spina Bifida

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

_____
Signature of Employee

_____ _____
Print Name Date

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AUTHORIZATION FOR RELEASE OF INFORMATION (We will require a separate authorization for release of psychotherapy notes.)

I authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Patient's Name: _____ _____ _____ _____

Last **First** **Middle** **Date of Birth**

Patient Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical reports; records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to:

Blue Cross and Blue Shield of Illinois
P.O. Box 7070
Downers Grove, IL 60515

- I understand the information obtained by use of this Authorization will be used by The Company to evaluate my claim for Critical Illness benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As may be required by law; or
  - As I further authorize.
- I further understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent The Company has taken action in reliance on this Authorization. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to The Company at the above address.
- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this signed Authorization.

Signature (Patient or Representative) _____

Print Name_____Date_____

If you are the legal representative of the patient we may ask for additional documentation.

Address: _____ _____ _____ _____

Street City State Zip

Phone No. _____

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SEASONS OF LIFE

If you have medical coverage with Blue Cross and Blue Shield of Illinois (BCBSIL) through your employer, you are eligible for special services through their Seasons of Life program. Seasons of Life staff provide personalized support and assistance with BCBSIL medical claims.

Participation in the Seasons of Life program is voluntary and does not affect your current BCBSIL medical Critical Illness Benefits.

If you have BCBSIL medical coverage through your employer and would like to be contacted by a Seasons of Life staff member please provide the information requested. By signing below, you authorize BCBSIL to release your contact information to the BCBSIL Seasons of Life staff.

BCBSIL Group Medical Number _____ **BCBSIL Member Medical ID** _____

Group Name _____

Signature _____ **Print Name** _____

BlueCross BlueShield of Illinois

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: 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.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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.

District of Columbia: 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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Maryland: Any person who knowingly or willingly 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.

New Mexico: 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 civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowingly 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.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: 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.

Tennessee: 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.

Washington: 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.

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

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A 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.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: 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.

Delaware: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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

New Hampshire: 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 NH RSA 638:20.

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

Texas: 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.

FOR APPLICATIONS ONLY:

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.