



WELLFLEET WORKPLACE

GROUP VOLUNTARY CRITICAL ILLNESS POLICY AND OPTIONAL RIDER CLAIM FORM

Submitting your claim

Submit your claim the way you like. Mail, email or fax your claim to:

Wellfleet Insurance Company

P.O. Box 15769

Springfield, MA 01115

Fax: 413-452-5486

Email: workplaceclaims@wellfleetinsurance.com

Helpful reminders

- Please complete all sections of this form, including the patient's name, diagnosis and dates of service.
- Note that a "UB04" (hospital bill), "HCFA1500" or an itemized bill is required with the claim submission.
- Make sure to sign and submit the "Authorization to Release Information to Wellfleet Form".
- The "Attending Physician's Statement" must be completed and signed by your attending physician.
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.
- Benefits may vary by product and/or state.
- We will notify you if additional information is needed.

Questions?

If you have any questions regarding available benefits or how to file your claim, or if you would like to appeal a determination, please contact our **Customer Care Team** at:

- workplaceclaims@wellfleetinsurance.com
- 1-855-664-5838, 8:30 a.m. - 5:00 p.m. EST

CERTIFICATE HOLDER/CLAIMANT INFORMATION

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

New claim Continued claim

Certificate number(s): _____

Certificate holder: First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Male Female

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Check here if address is new

Phone #: _____ E-mail: _____

Preferred communication with Wellfleet: Email Mail

Employer: _____ Occupation: _____

Claimant (if different): First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ Male Female

Relation to Insured: Self Spouse Child Other _____



CRITICAL ILLNESS BENEFIT

Please check the benefits that apply and attach the respective medical record documentation of your condition.

- Addison's Disease:** Provide medical documentation of disease.
- Advanced Dementia:** Provide medical documentation of disease.
- ALS:** Provide medical documentation of disease.
- Aneurism:** Provide medical documentation of disease.
- Angioplasty:** Provide medical documentation that the physician recommends surgery.
- Benign Brain Tumor:** Provide medical documentation
- Bone Marrow or Stem Cell Transplant:** Provide medical documentation.
- Cancer:** Provide pathology report.
- Carcinoma in Situ:** Provide pathology report.
- Coma:** Provide medical documentation that profound unconsciousness lasted for at least 14 days.
- Coronary Artery Bypass:** Provide medical record that the physician recommends surgery.
- End-Stage Renal Failure:** Provide medical records documenting failure in both kidneys and proof of dialysis at regular weekly intervals.
- Heart Attack:** Provide electrocardiographic proof and lab findings of elevated cardiac enzymes. Additional test that results may be required include: stress echo, cardiac catheterization, PECT or Thallium.
- Huntington Disease:** Provide medical documentation of disease.
- Infectious Disease:** Provide medical documentation of disease.
- Hearing Loss:** Provide medical documentation that hearing loss is not due to congenital birth defect, developmental delays or can be corrected by any procedure, aid or device.
- Loss of Sight:** Provide medical documentation that loss of sight is total and irrecoverable.
- Major Organ Failure:** Provide medical record that physician has placed person on "UNOS". Does not include transplants involving mechanical or non-human organs.
- Multiple Sclerosis:** Provide medical documentation of disease. Must meet specifics listed in the Certificate.
- Myasthenia Gravis:** Provide medical documentation of disease.
- Occupational HIV:** Provide medical documentation that is reported by the covered person that HIV was caused by accidental needle stick or sharp injury while performing occupational duties.
- Occupational Hepatitis B or C:** Provide medical documentation that is reported by the covered person that Hepatitis B or C was caused by accidental needle stick or sharp injury while performing occupational duties.
- Paralysis:** Provide medical documentation and Attending Physician's Statement showing spinal cord injury resulting in paraplegia or quadriplegia.
- Parkinson's Disease:** Provide medical documentation of disease.
- Severe Burns:** Provide medical documentation.
- Skin Cancer:** Provide pathology report showing abnormal growth of skin cells.
- Stroke:** Provide medical record documentation of permanent neurological deficit for 30 days or more (CAT scan, MRI).
- Sudden Cardiac Death:** Provide certified death certificate (must be an original).
- Systemic Lupus Erythematosus:** Provide medical documentation.
- Systemic Sclerosis:** Provide medical documentation.
- Transient Ischemic Attacks (TIA):** Provide medical documentation.
- Type 1 Diabetes:** Provide medical documentation showing disease.

Children's-only conditions

- Cerebral Palsy:** Provide medical documentation of disease.
- Congenital Defect:** Provide medical documentation of disease showing abnormalities in the structure of body parts.



- Genetic Disorder:** Provide medical documentation of disorder showing abnormalities in an individual's DNA.
- Type 1 Diabetes:** Provide medical documentation showing disease.
- Congenital Metabolic Disorder:** Provide medical documentation of disorder.

Optional riders

Check those that apply. Note that you may not have purchases the available optional rider(s). Please see your certificate and rider(s) for more information.

- Health Screening Rider:** Provide bill for Wellness initiative and/or screening(s). See certificate for list of covered tests.
- Enhanced Cancer Rider:** Provides additional benefits when a specified covered disease is covered. Please check all that apply. Medical records or billing notices must be submitted.

<input type="checkbox"/> Cancer Treatment	<input type="checkbox"/> Blood/Plasma/Platelets
<input type="checkbox"/> Outpatient Surgery	<input type="checkbox"/> Hospital Confinement
<input type="checkbox"/> Inpatient Surgery	<input type="checkbox"/> Durable Goods & Equipment
<input type="checkbox"/> Extended Care – Facility Benefit	<input type="checkbox"/> Extended Care – Home Health Care Benefit
<input type="checkbox"/> National Cancer Institute Evaluation	<input type="checkbox"/> Experimental Drug or Medical Service
- Caregiver Rider:** Caregiver means a covered person who provides caregiver functions to a covered person who is either the insured, the covered spouse or the covered child. Provide physician's orders recommending a caregiver and that the caregiver is not able to perform their usual duties of employment due to providing caregiver functions.

CERTIFICATION

Please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete and correctly recorded.

Please also remember to sign and date the attached authorization required to process your claim.

Signature: _____ Print Name: _____ Date: _____



ATTENDING PHYSICIAN'S STATEMENT

To be completed and signed by the attending physician.

Patient's Name: _____ DOB: _____

1) Diagnosis: _____

2) When did symptoms first appear (M/DD/YYYY)? _____

3) When did patient first consult you for this condition (M/DD/YYYY)? _____

4) Has patient ever had same or similar condition? Yes No

If "yes", state when and describe: _____

5) Describe any other diseases or infirmity affecting present condition. _____

6) Nature of surgical procedure, if any (describe fully). _____

7) Date patient last examined by you: _____

Frequency of visits: weekly monthly other _____

8) If patient is hospitalized, provide name and address of hospital.

Hospital: _____ City: _____ State: _____

9) Date admitted (M/DD/YYYY): _____ Date discharged (M/DD/YYYY): _____

10) Name and contact info of referring physician, if any.

Name: _____ Phone: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Return to work assessment

Did you advise the patient to stop work? Yes No

If yes, when (MM/DD/YYYY)? _____

Have you advised patient to return to work? Yes No

If yes, what is the expected return to work date (MM/DD/YYYY)? _____ Full-Time Part-Time

If the patient can return to work, are there restrictions? Yes No

If yes, describe: _____

If no, please indicate the restrictions and limitations that prevent the patient from returning to work: _____

Physician verification

Signed: _____ Date: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Please check this box if you or your authorized representative would like to receive a copy of this form.

Claimant Information

Complete the necessary information for the claimant whose information will be released.

Name: _____
(Last, First, Middle)

Date of Birth: ____/____/____

Other Name Used: _____

Social Security Number: ____-____-____

Signature of Claimant: _____

Date signed: ____/____/____

I authorize any: licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer; to release any and all of the following information to Wellfleet or to persons or other organizations providing claims management services:

Authorized Representative Information

Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless a parent is signing for patient under 18.

Name: _____
(Last, First, Middle)

Mailing Address: _____

Relationship to Claimant: _____

Phone: ____-____-____

Description of the information to be disclosed

I understand that this Authorization for Release of Information specifically includes my permission to disclose my entire record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records (excluding psychotherapy notes); claims history including but not limited to Prescription Drug Databases, pharmacy benefits management companies, ambulance, insurance companies, medical transcripts, or the MIB; and, alcohol or drug abuse including any data protected by Federal Regulation 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV-related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations at the federal, state or local level. I also understand that work and financial information are necessary to process my claim and I give my permission to disclose related records about me including but not limited to: employment, compensation, compensation sources, insurance companies, financial institutions, and government entities. By signing below, I consent to the disclosure of such information but only in accordance with the laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

Expiration

Unless revoked as discussed below, this Authorization will be considered valid for a period of twenty-four (24) months from the date this form is signed or for the duration of the claim for benefits, whichever the shorter.



Right to Revoke

I have the right to revoke this authorization, in writing, at any time by contacting Wellfleet at the address provided on the previous page. I understand that revocation is not effective to the extent that Wellfleet has taken action in reliance on this authorization.

Claimant Rights

1. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.



FRAUD NOTICES

For residents of all states, other than those listed below. 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.

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.

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.

California. For your protection California law requires the following to appear on this form: 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.

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.

Delaware Idaho, Indiana & Oklahoma: 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.

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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky. 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.

Maine: 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 or a denial of insurance benefits.

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

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 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.

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.

New York: 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



shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with 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.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

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 are 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.

Tennessee, Virginia & 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.

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.