



CRITICAL ILLNESS CLAIM FORM

Instructions For Filing a Critical Illness Claim:

1. Please complete **Section 1 - Claimant's Statement**.
2. Please complete **Section 2 - Critical Illness Information**. (If additional space is needed to include all names of doctors or hospitals, please attach a separate piece of paper)
3. Please have your attending physician complete **Section 3 - Attending Physician's Statement**.

Instructions For Filing a Cancer Benefit (if applicable):

1. Please complete **Section 1 - Claimant's Statement**.
2. Please complete **Section 2 - Critical Illness Information**.
3. Attach copies of the Eligible Medical Expenses incurred. (Please refer to your policy for a description of the Eligible Medical Expenses)

Send your completed claim form to

Triada Claims • 10713 West Sam Houston Parkway N,
Suite 100 Attn: Claims Dept. • Houston, TX 77064
Telephone: 1-877-387-4232 Fax: 281-343-3613



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Section 1 - Claimant's Statement

Insured's First Name: _____ Insured's Last Name: _____

Social Security Number: _____ Date of Birth (mm/dd/yy): _____

Group Number: _____ Member #: _____ Phone #: _____

Patient's First Name: _____ Patient's Last Name: _____

Relationship to Insured: _____ Patient's Date of Birth (mm/dd/yy): _____ Patient's Date of Death: _____
(if applicable)

Section 2 - Critical Illness Information

What is the Specific Critical Illness? Please check the appropriate box.

| | |
|--|---|
| <input type="checkbox"/> Cancer/Carcinoma In Situ/Skin Cancer | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Myocardial Infarction (Heart Attack) | <input type="checkbox"/> Severe Burns |
| <input type="checkbox"/> Coronary Artery Bypass Surgery/Angioplasty/Stent | <input type="checkbox"/> Coma |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cerebral Palsy/Cleft Lip or Palate/Down Syndrome/Cystic Fibrosis/Spina Bifida | <input type="checkbox"/> Loss of Sight/Hearing/Speech |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) | <input type="checkbox"/> Occupational HIV |
| <input type="checkbox"/> Renal Failure (Kidney Failure) | <input type="checkbox"/> Benign Brain Tumor |
| <input type="checkbox"/> Major Organ Transplant (Covered Organs: heart, lung, liver, kidney or pancreas) | |

Date critical illness diagnosed: _____ Have you ever had the same or similar condition? Yes ☐ No ☐

If Yes, please explain:

On what date did you first consult a medical practitioner in connection with your critical illness?: _____

Please indicate the name and address of the Physician seen: _____

Name and Specialty: _____

Street Address (City, State, Zip): _____

Please provide the name and address of the Primary Care Physician: _____

Name: _____

Street Address (City, State, Zip): _____

If the Critical Illness required hospitalization, provide the name and address of the treating facility and dates of confinement: _____

Name of Facility: _____ Date Hospitalized From: _____ To: _____

Street Address (City, State, Zip): _____

Please provide details of any other doctors or specialists who have been consulted in connection with this Critical Illness

Name: _____ Address: _____ Dates Seen: _____

Name: _____ Address: _____ Dates Seen: _____

If this policy has been in force less than 2 years, please provide the names and addresses of all physicians, not mentioned above, that have been consulted in the past 5 years:

Name: _____ Address: _____ Dates Seen: _____

Name: _____ Address: _____ Dates Seen: _____

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge.

Please refer to the "Fraud Warning Notices" insert for your state.

Signature of Claimant: _____ Printed Signature: _____ Date: _____



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Use this section for Cancer, Carcinoma in Situ or Skin Cancer

Patient's Name: _____ Date of Birth: _____ Certificate#: _____

Covered conditions are limited to the following:

The term "**Carcinoma in Situ**" means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

The term "**Skin Cancer**" means basal cell carcinoma, squamous cell carcinoma and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

The term "**Cancer**" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia.

Please Note: Policy/certificate language and definitions may vary based on state and policy form variations. The actual policy/certificate language and definitions will control.

1. On what date did the patient first have signs or symptoms? _____
2. When did the patient first consult you for this condition? _____
3. On what date was this cancer diagnosed? _____
4. Was the patient confined on an inpatient basis in a hospital for more than 30 days? Yes No
5. Please provide the following details concerning the cancer (attach copy of pathology report):
Type of Tumor: _____ Site of Tumor: _____ Staging of Tumor: _____
6. Using the definitions above, was the patient's condition diagnosed as (check one):
Carcinoma in Situ Cancer Skin Cancer
7. Has the patient previously ever been diagnosed with cancer/carcinoma in situ/skin cancer or had any predisposing condition or disorder?
Yes No
If yes, please explain: _____
8. Please provide the names and addresses of other physicians who attended this patient for this or any related conditions:
Name: _____ Address: _____
Name: _____ Address: _____

Section 3 - Attending Physician's Statement

Attending Physician's Signature

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

Name: _____ Specialty: _____ Telephone: _____
(Attending Physician) Please Print

Address: _____
(City, State, Zip)

Signature: _____ Date: _____ Fax: _____

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NOTICE OF INFORMATION PRIVACY PRACTICES

Protecting Your Information

TRIADA HEALTH (herein referred to as “we,” “us,” “our”) maintains physical, electronic and procedural safeguards to protect your nonpublic personal information.

Collecting Information

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- Information we collect may include all the information you share with us, including for example, your:
 - name
 - address
 - telephone number
 - date of birth
 - social security number
 - employer name and income
 - beneficiary data
 - financial account numbers
 - medical information
 - and other information you share with us
- We may also collect data we receive from other sources, as allowed by law, which may include:
 - medical information
 - consumer report information in accordance with the Fair Credit Reporting Act
 - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
 - information to assist us in complying with state and federal laws

Sharing Information

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- We may share information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:
 - process or service your insurance transactions with us
 - perform underwriting, administrative, account maintenance and claims functions
 - provide customer service or reinsurance coverage
 - prevent fraud
 - perform other business functions on our behalf
- We may also share your information with:
 - a consumer reporting agency in accordance with the Fair Credit Reporting Act
 - a third party to comply with federal, state or local laws, subpoenas, or summonses
 - regulators
 - or as otherwise permitted or required by law

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

Sharing Information

You have the right to request access to all the information we have on you. You must make your request in writing to the address below.

Admentments to Your Information

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

TRIADA HEALTH
10713 W. Sam Houston Pkwy. N • Suite 100 • Houston, TX 77064
Telephone: 1-800-994-1682 Fax: 281-343-3613



FRAUD WARNING NOTICES FOR CLAIMS

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

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.

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: 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: 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 an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any 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.

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.

LOUISIANA: 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.

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 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.

MINNESOTA: A person who files a claim with intent to defraud or helps commit 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 Rev. Stat. Ann. §638:20.

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PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

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 any false, incomplete or misleading information is guilty of a felony.

OREGON: 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 may be guilty of insurance fraud.

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.

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.

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.

VIRGINIA: 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 MAY HAVE VIOLATED THE STATE LAW.

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 an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: 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.



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