



**SECTION 2: Physician Statement – Have your physician complete this section AND attach an itemized bill (HCFA 1500 or UB92)**

Last (Patient)		First(Patient)	MI
Patient's Address		City/State	Zip Code
<input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date: ____/____/____	
Date patient first consulted you for this condition: ____/____/____		When was the patient first diagnosed with this condition? ____/____/____	
If hospitalized, please provide dates: ____/____/____		Applicable Diagnosis Codes:	
Name & address of facility where services rendered:		Applicable Procedure (CPT) Codes:	
Has patient ever had same of similar condition? (If yes, provide dates and describe)		Have you previously treated this patient? (If yes, please provide the illness and dates treated).	
Does the patient suffer from any chronic illnesses? (If yes, please identify illnesses)		Does the patient take any prescription medication regularly? (If yes, please identify the medications).	
Has any other physician ever treated the patient for this condition?	Name and address of Physician who previously treated this patient:		
Name and Address of Referring Physician:	Referring Physician's phone: _____		
Dates patient treated: ____/____/____ - ____/____/____			

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
 Physician's Name - printed      Address (City , State and Zip Code)

\_\_\_\_\_  
 Physician's Phone Number      Physician's Fax Number

\_\_\_\_\_  
 Physician's Signature(including degrees and credentials)      Date

*The following information is required in order to process your claim for benefits.*

*(Additional information may be requested to determine benefits).*

- **Advanced Alzheimer's Disease:** Please submit medical documentation from a board certified neurologist or board qualified geriatrician substantiating that the covered person has experienced permanent loss of the ability to; remember, reason; understand and express ideas and include a confirmed diagnosis of Alzheimer's Disease. The medical documentation must also show that the covered person must permanently require daily supervision and assistance for at least 3 activities of daily living.
- **Blindness:** Diagnosis of Blindness and an Ophthalmologist's report substantiating a "diagnosis of irreversible reduction in sight as a result of Sickness or Injury, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together."
- **Major Burns:** Please submit records that substantiate "Acute full thickness or third degree burns covering at least 20% of a Covered Person's body surface area."
- **Cancer Type A:** Pathology report, operative report (if available), and laboratory records substantiating malignant neoplasm (including hematologic malignancy).
- **Cancer Type B:** Pathology report confirming the pathological diagnosis of In-Situ cancer that affects only the area of the body in which it began, has not spread and, is classified by pathology as TisN0M0.
- **Coma/Comatose:** Hospital records and test results from initial onset substantiating a state of unconsciousness, characterized by the absence of any voluntary, purposeful movement, from which the covered Person cannot be aroused for a period of at least [96 hours].
- **Coronary Artery Bypass:** Surgical report for the procedure(s) which uses a saphenous vein or internal mammary artery graft to surgically bypass obstructions as defined by the policy.
- **Deafness:** Medical documentation from an audiologist supporting a diagnosis of an irreversible loss of hearing, as result of sickness or injury, for all sounds in both ears with a diagnosis of deafness. The medical documentation must also include audiometric and auditory threshold tests indicating an auditory threshold of 90 decibels or less while using a hearing aid.
- **End Stage Renal Disease (Kidney Failure):** Medical documentation substantiating a diagnosis of end stage renal disease and chronic, irreversible failure of both kidneys which requires treatment by regular dialysis for at least 90 days or kidney transplant.

- Heart Attack: Medical documentation substantiating a diagnosis of a new myocardial infarction . The basis of the diagnosis must include: typical clinical presentation; serial measurements of cardiac biomarkers showing a pattern and level consistent with a Heart Attack; and new electrocardiographic changes consistent with acute myocardial infarction.
- Heart Valve Surgery: Surgical report for the procedure(s) which indicate having undergone a median sternotomy in order to replace or repair one or more heart valves.
- Loss of Limbs: Surgical report for a procedure(s) to sever two or more limbs at or proximal to the wrist or ankle.
- Major Organ Transplant: Medical documentation substantiating surgery where the covered person is a recipient of a transplant as defined by the policy.
- Paralysis: Diagnosis of Paralysis with medical documentation of total and irreversible loss of use of two or more Limbs continuously for 180 days and is expected to last for 12 months or longer.
- Stroke: Medical documentation and MRI report supporting the new diagnosis of brain tissue infarction due to acute cerebrovascular incident, embolism, thrombosis or hemorrhage. This documentation must also substantiate neurological damage persisting for at least 30 days and that the damage is expected to be permanent.

**SECTION 3: Claimant Authorization and Signature**

HIPAA AUTHORIZATION

Policyholders Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Claimant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me to provide all such information as may be requested by Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including but not limited to, EMSI.

This authorization includes any and all information you have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Time Insurance Company, including but not limited to, EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as the original.

I understand that this authorization is required in order to enable Time Insurance Company to make payment determinations relating to me and/or my minor children. I may refuse to sign this authorization; however Time Insurance Company may not be able to make a payment determination without the required information. Please forward the requested information to: Assurant Supplemental Coverage, P.O. Box 2829, Clinton, IA 52733-2829. You may also fax this information to: 608-373-9503

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Supplemental Coverage Coverage, P.O. Box 2829, Clinton, IA 52733-2829. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires when I am no longer an insured of Time Insurance Company.

Signature of Claimant or Representative\* \_\_\_\_\_ Date: \_\_\_\_\_

\*If you are the individual's representative and are not the legal guardian, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

**PLEASE RETAIN A COPY FOR YOUR RECORDS**

**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.**