CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427 • Columbia, South Carolina 29202 • Phone (800) 433-3036
Fax (866) 849-2970 Email: csc@caicworksite.com

CLAIM FORM

Please Read Instructions Before Completing

PART A POLICYHOLDER/CLAIMANT'S STATEMENT

1

POLICYHOLDER'S NAME	POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX

2

POLICYHOLDER'S ADDRESS STREET	CITY	STATE	ZIP CODE

3

CLAIMANT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	RELATIONSHIP TO POLICYHOLDER	POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)

4

POLICY HOLDER'S OCCUPATION	DESCRIBE WHEN AND HOW YOUR ACCIDENT OCCURRED OR THE ONSET AND NATURE OF YOUR ILLNESS.

5

IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?
☐ NO ☐ YES DATE REPORTED TO YOUR EMPLOYER:	☐ NO ☐ YES STATUS ☐ APPROVED ☐ PENDING ☐ DENIED APPEALING Y N

6

DATE SYMPTOMS FIRST APPEARED	TREATED BY: NAME	ADDRESS	CITY	STATE	ZIP CODE
	IF HOSPITALIZED: NAME	ADDRESS	CITY	STATE	ZIP CODE
	DATES HOSPITALIZED: FROM	THROUGH			

7

DATES YOU DID NOT WORK AT ALL.	DATES YOU WORKED LESS THAN FULL TIME.	DATE YOU RETURNED OR EXPECT TO RETURN TO WORK.
FROM THROUGH	FROM THROUGH	FULL-TIME PART-TIME

8

PRIMARY DOCTOR NAME	TREATING DOCTOR NAME	REFERRING DOCTOR NAME
ADDRESS	ADDRESS	ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
PHONE NUMBER	PHONE NUMBER	PHONE NUMBER

9

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

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.

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative

Policyholder's Signature: Date: Claimant's Signature: Date:

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CLAIM FORM

PART B EMPLOYER'S STATEMENT

(To be completed by your Benefits Department unless self-employed)

1	EMPLOYEE'S NAME:	EMPLOYEE ID NUMBER	DATE OF BIRTH	DATE OF HIRE

2

OCCUPATION AT TIME LAST WORKED _____

EMPLOYEE'S JOB TITLE DUTIES INCLUDE

LIFTING ❑LESS THAN 15LBS. ❑15 TO 44 ❑OVER 45 **STOOPING/BENDING** ❑NONE ❑SELDOM ❑FREQUENT **REPETITIVE** ❑NONE ❑SELDOM ❑FREQUENT

CRAWLING/CLIMBING/KNEELING ❑NONE ❑SELDOM ❑FREQUENT **REACHING/PULLING/PUSHING** ❑NONE ❑SELDOM ❑FREQUENT

MANAGEMENT DUTIES ❑NONE ❑SELDOM ❑FREQUENT

SITTING (NUMBER OF HOURS EACH DAY) _____ **STANDING/WALKING** (HOURS EACH DAY) _____

3	DATE EMPLOYEE WAS ACTUALLY LAST PRESENT AT WORK	WORK SCHEDULE AT TIME LAST WORKED: NO. OF DAYS/WEEK: NO. OF HOURS/DAY:
4	DATES EMPLOYEE DID NOT WORK AT ALL: FROM THROUGH	DATES EMPLOYEE WORKED LESS THAN FULL-TIME HOURS: FROM THROUGH
5	DATE THE EMPLOYEE RETURNED TO FULL-TIME WORK OR LIGHT DUTY/PART-TIME:	IF THE EMPLOYEE HAS NOT RETURNED, IS LIGHT DUTY AVAILABLE?

6	DID THE CLAIM RESULT FROM JOB ACTIVITY? (**IF "YES," ATTACH FIRST REPORT OF INJURY – ACCIDENT REPORT.**) ☐ NO ☐ YES	HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ NO STATUS ☐ YES ☐ APPROVED ☐ PENDING ☐ DENIED, IF SO, HAS THE EMPLOYEE APPEALED Y N	WORKER'S COMPENSATION WEEKLY AMOUNT $ _____
7	HAS THE EMPLOYEE RECEIVED ANY OTHER INCOME AS A RESULT OF DISABILITY? ☐ NO ☐ YES	SALARY CONTINUANCE, SICK PAY OR VACATION WEEKLY BENEFIT _____ DATE CEASED	OTHER TYPE _____. WEEKLY BENEFIT _____ DATE CEASED _____.
8	IS ANY PORTION OF THE EMPLOYEE'S POLICY PAID FOR BY THE EMPLOYER? ☐ NO ☐ YES IF "YES," WHAT PERCENTAGE?	**IS THE EMPLOYEE'S POLICY PAID FOR WITH PRE-TAX DOLLARS (SECTION 125)?** ☐ NO ☐ YES	WHAT IS THE EMPLOYEE'S BASIC MONTHLY EARNINGS? $ _____

AUTHORIZED EMPLOYER'S SIGNATURE

9	EMPLOYER'S COMPANY NAME:	TELEPHONE NUMBER: FAX NUMBER:
10	ADDRESS:	NAME AND TITLE OF PERSON COMPLETING THIS FORM:
11	SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE:	DATE:

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CLAIM FORM

PART C ATTENDING PHYSICIAN'S STATEMENT

(To be completed by your current treating physician)

1	PATIENT'S NAME		DATE OF BIRTH
2	WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	DATE PATIENT BECAME DISABLED DUE TO PRESENT CONDITION?	HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐YES ☐ NO DATE:
3	IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF THE PATIENTS EMPLOYMENT? ☐ NO ☐ YES IF "YES," DATE ACCIDENT OCCURRED: _____.		NAMES AND ADDRESSES/ REFERRING OR OTHER TREATING PHYSICIANS

DIAGNOSIS

4	DIAGNOSIS (INCLUDING COMPLICATIONS)	ICD CODE(S):	SUBJECTIVE SYMPTOMS	IF PREGNANT: EDC:
5	OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS.)			LMP:

TREATMENT

6	DATE FIRST TREATED FOR THIS CONDITION	LAST DATE TREATED FOR THIS CONDITION	FREQUENCY ☐ WEEKLY ☐ MONTHLY ☐ OTHER
7	NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.) CAI001DI	DID PATIENT HAVE SURGERY? ☐ NO ☐ YES DATE: DESCRIBE SURGERY: CPT CODE:	

PROGNOSIS

8	HAS THE PATIENT: ☐ RECOVERED? ☐ IMPROVED? ☐ UNCHANGED? ☐ RETROGRESSED?	IS THE PATIENT: ☐ AMBULATORY? ☐ HOUSE CONFINED? ☐ BED CONFINED? ☐ HOSPITAL CONFINED?
9	HAS THE PATIENT BEEN HOSPITAL CONFINED? ☐ NO ☐ YES CONFINED FROM _____ TO _____.	IF YES, GIVE NAME AND ADDRESS OF HOSPITAL:
10	IS THE PATIENT NOW TOTALLY DISABLED FROM? PATIENT'S JOB? ☐ NO ☐ YES ANY OTHER WORK? ☐ NO ☐ YES	
11	WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE PATIENT'S CONDITION? ☐ 1 MO. ☐ 1-3 MO. ☐ 3-6 MO. ☐ 6-9 MO. ☐ 9-12MO. ☐ NEVER	WHEN DO YOU ANTICIPATE A RETURN TO WORK WITHOUT RESTRICTIONS?
12	WHEN COULD A TRIAL EMPLOYMENT COMMENCE? DATE (PATIENT'S JOB): _____. ☐ FULL-TIME ☐ PART-TIME ☐ LIGHT DUTY DATE (ANY OTHER WORK): _____. ☐ FULL-TIME ☐ PART-TIME ☐ LIGHT DUTY	

IMPAIRMENTS

13	PHYSICAL IMPAIRMENTS (As defined in the Federal Dictionary of Occupational Titles) ☐ CLASS 1 - No limitation of functional capacity; capable of heavy work. No restrictions (0-10%) ☐ CLASS 2 - Medium manual activity. (15-30%) ☐ CLASS 3 - Slight limitation of functional capacity; capable of light work. (35-55%)	☐ CLASS 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%) ☐ CLASS 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity (75-100%)
14	RESTRICTIONS AND LIMITATIONS (What specific activities is the patient incapable of performing)	

REMARKS

15	REMARKS (Additional comments regarding the patient's condition)

"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 (Attending Physician) PLEASE PRINT	FAX NUMBER	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, 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: 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 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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: **WARNING:** 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.

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: 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.

RHODE ISLAND and 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.