



CRITICAL ILLNESS CLAIM FORM INSTRUCTIONS

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF NY

Critical Illness Claim

Please complete the Certificateholder/Claimant's Information section and attach a copy of the claimant's birth certificate. If additional space is needed to include all names of doctors or hospitals in attendance, please attach a separate piece of paper for your additional listings. Please read the authorization section and sign in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. Failure to sign this form will delay the processing of your claim. Have your attending physician complete the section on the reverse side of the form that corresponds to the specific critical illness for which the claim is being made. If you are filing for cancer under the critical illness plan, please attach the pathology report that confirms the diagnosis.

Health Screening Claim

If you are filing for the health screening benefit, complete the first three lines of the Policyholder/Claimant Information section and the Health Screening Information section. Attach documentation indicating the type of test performed, the date the test was performed, and the charges incurred.

Send all claims to:

Critical Illness Claims Processing Unit
Post Office Box 427
Columbia, South Carolina 29202
Phone (866)849-2964 Fax (866)849-2974

CERTIFICATEHOLDER/CLAIMANT'S INFORMATION				
EMPLOYER'S NAME				
CERTIFICATEHOLDER'S NAME	CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX
CERTIFICATEHOLDER'S ADDRESS			CERTIFICATEHOLDER'S TELEPHONE NO.	
CLAIMANT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	CLAIMANT'S DATE OF BIRTH	CLAIMANT'S DATE OF DEATH (IF APPLICABLE)	
WHAT IS THE SPECIFIC CRITICAL ILLNESS FOR WHICH THE CLAIM IS BEING MADE	WHEN WAS THE CRITICAL ILLNESS FIRST DIAGNOSED	HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION: <input type="checkbox"/> YES <input type="checkbox"/> NO		
LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIANS FOR THE CRITICAL ILLNESS (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)				
IF THE CRITICAL ILLNESS REQUIRED HOSPITALIZATION, PROVIDE THE NAME AND ADDRESS OF THE TREATING FACILITY (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)				
HEALTH SCREENING INFORMATION				
WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:				
<input type="checkbox"/> STRESS TEST ON A BICYCLE OR TREADMILL	<input type="checkbox"/> FASTING BLOOD GLUCOSE TEST	<input type="checkbox"/> MAMMOGRAPHY		
<input type="checkbox"/> SERUM CHOLESTEROL TEST (HDL AND LDL)	<input type="checkbox"/> BONE MARROW TESTING	<input type="checkbox"/> BLOOD TEST FOR TRIGLYCERIDES		
<input type="checkbox"/> CA 15-3 (BLOOD TEST FOR BREAST CANCER)	<input type="checkbox"/> CA 125 (BLOOD TEST FOR OVARIAN CANCER)	<input type="checkbox"/> BREAST ULTRASOUND		
<input type="checkbox"/> CHEST X-RAY	<input type="checkbox"/> COLONOSCOPY	<input type="checkbox"/> CEA (BLOOD TEST FOR COLON CANCER)		
<input type="checkbox"/> HEMOCULT STOOL ANALYSIS	<input type="checkbox"/> THERMOGRAPHY	<input type="checkbox"/> FLEXIBLE SIGMOIDOSCOPY		
<input type="checkbox"/> PSA (BLOOD TEST FOR PROSTATE CANCER)	<input type="checkbox"/> SERUM PROTEIN ELECTROPHORESIS (MYELOMA)	<input type="checkbox"/> PAP SMEAR		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> OTHER		
DATE THE HEALTH SCREENING TEST WAS PERFORMED				
AUTHORIZATION				
Several states require that the following statement appear on the claim forms:				
Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.				
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.				
Policyholder's Signature: _____		Date: _____		
Claimant's Signature: _____		Date: _____		

CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT			
PATIENT'S NAME		DATE OF BIRTH	DATE OF DEATH (IF APPLICABLE)
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? <input type="checkbox"/> YES, WHEN _____ <input type="checkbox"/> NO	DIAGNOSIS (INCLUDING COMPLICATIONS)	
CANCER/CARCINOMA IN SITU			
DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED)		WAS THE CANCER/CARCINOMA IN SITU <input type="checkbox"/> PATHOLOGICALLY <input type="checkbox"/> CLINICALLY DIAGNOSED DIAGNOSED, OR	
IF THE CANCER/CARCINOMA IN SITU WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA IN SITU WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.			
MYOCARDIAL INFARCTION (HEART ATTACK)			
DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:			
1. ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKG'S AND REPORTS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2. WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHOSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3. DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4. DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)			
CORONARY ARTERY BYPASS SURGERY			
DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT CONDITION CAUSED THE NEED FOR CORONARY ARTERY BYPASS SURGERY?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?		
MAJOR ORGAN TRANSPLANT			
DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, LUNG, KIDNEY, OR PANCREAS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?		
STROKE			
DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTEBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN) REPORT OR MAGNETIC RESONANCE IMAGING (MRI) REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?)			
RENAL FAILURE			
DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS)			
WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE?		WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?	
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 (ATTENDING PHYSICIAN) PLEASE PRINT		DEGREE	TELEPHONE NUMBER
ADDRESS		CITY	STATE ZIPCODE
SIGNATURE		DATE	MEDICAL ID#

FRAUD WARNING NOTICE
For use with Claim Forms

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.