KEMPER Health

KEMPER HEALTH

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

A **Kemper Health** Company
P.O. Box 3252, Milwaukee, WI 53201-3252
Telephone: 877.851.0890 Fax: 877.721.2343
Email: customerservice@kemperbenefits.com Website: kemperbenefits.com

Critical Illness Wellness Claim

Instructions to File a Claim:

- Please complete Insured/Claimant Statement and mail or fax the completed form to the address or fax number indicated above.
- In order to document the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please attach a copy of itemized bill indicating: patient name, date of service, name of provider, type of service, and diagnosis code.

Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/ Certificate #	Social Security No.	Date of Birth	Sex

Address (Street, City, State, Zip)	Phone Number (With Area Code)

Claimant's Name	Date of Birth	Relationship to Insured

Please circle the appropriate wellness screening and provide itemized bill.

Abdominal aortic aneurysm ultrasound	Fasting blood glucose test
Blood test for triglycerides	Flexible sigmoidoscopy
Bone marrow testing	Hemoccult stool analysis
Breast ultrasound	Mammography
CA 15-3 (blood test for breast cancer)	Pap Smear
CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)
Carotid ultrasound	Serum cholesterol HDL/LDL
CEA (blood test for colon cancer)	Serum protein electrophoresis (blood test for myeloma)
Chest x-ray	Stress Test
Colonoscopy	Thermography
CT Angiography	Annual physical examinations
EKG	Immunizations
Double contrast barium enema	

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS RESPRESNTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORAMTION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE_____ INSURED'S SIGNATURE: _____

DATE_____ CLAIMANT'S SIGNATURE: _____