

CRITICAL ILLNESS CLAIM FORM

Instructions to File a Claim:

- Claims must be submitted within 1 (one) year from the date of service.
- Please complete Claim Form and mail, fax or email the completed form to the address or fax number indicated above.
- To verify the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please have the treating physician complete the Attending Physician Statement. Your physician may mail, fax or email the completed form to the address or fax number indicated above.
- Please have your physician provide the applicable documents in order to avoid a delay in processing.
- Please review your certificate for benefits that may be applicable.

Insured/Claimant Information				
Insured's Name <i>(Last, First, Middle)</i>	Policy/Certificate #	Social Security No.	Date of Birth	Sex
Address <i>(Street, City, State, Zip)</i>				
Phone Number <i>(With Area Code)</i>	Email			
Claimant's Name <i>(Person who is sick)</i>	Date of Birth	Relationship to Insured		
Critical Illness Diagnosis Information				
Nature of illness:	Date of Diagnosis:			
When did symptoms first appear?	Date first treated?			
Have you ever been diagnosed with the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____			
Name and address of physician: (list all physicians consulted)				
Non-Local Transportation and Lodging (outpatient)				
Did claimant travel more than 50 miles one way for outpatient treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and address of physician/facility:		
Outpatient Treatment Dates: _____				
<input type="checkbox"/> Transportation: <input type="checkbox"/> Auto <input type="checkbox"/> Plane <i>(Attach copy of ticket)</i>	<input type="checkbox"/> Lodging: <i>(Provide lodging receipt/proof of lodging. Must include dates of stay, name, and address of lodging facility.)</i>			

Family Member Transportation and Lodging (inpatient)			
Was claimant confined to a hospital for this condition, more than 50 miles one way from the claimant's legal address? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please provide name and address of hospital:	
Admission Date: _____	Discharge Date: _____		
Immediate Family Member's Name:		Immediate Family Member's Relationship to Insured:	
<input type="checkbox"/> Transportation: <input type="checkbox"/> Auto <input type="checkbox"/> Plane (<i>Attach copy of ticket</i>)		<input type="checkbox"/> Lodging: <i>(Attach receipt/proof of lodging. Must include dates of stay, name, and address of lodging facility.)</i>	
Second Opinion			
Was surgery or treatment recommended by a Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please provide name and address of second Physician:	
Did the Insured Person choose to obtain an evaluation with a second Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
AUTHORIZATION			
I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN 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 REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION 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, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.			
INSURED'S SIGNATURE:		DATE:	
CLAIMANT'S SIGNATURE:		DATE:	

Critical Illness Attending Physician's Statement

Must be completed by physician. Please complete all applicable questions and provide copies of the supporting documentation.

Patient Information			
Patient's Full Name		Policy or Certificate Number	Date of Birth
Diagnosis? (ICD 10 code)	Date of Diagnosis?	When did symptoms first appear?	When did the patient first consult you for this condition?
All Diagnoses Not Listed Below			
Please attach copies of medical records documenting diagnosis.			
Advanced Alzheimer's Disease / Advanced Parkinson's Disease / Huntington's Disease / Multiple Sclerosis (MS) / Severe Arthritis / Severe Osteoporosis			
<input type="checkbox"/> Clinical diagnosis information <i>(Please attach copies of medical records documenting diagnosis)</i>	Does patient require substantial physical assistance from another adult to perform Activities of Daily Living. <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, number required? <input type="checkbox"/> 2 <input type="checkbox"/> 3
Cancer			
<input type="checkbox"/> Pathologically diagnosed <i>(Please attach a copy of the pathology report.)</i>	<input type="checkbox"/> Clinically diagnosed <i>(Please provide the reasons that pathological diagnosis was not obtained and attach medical documentation that supports the diagnosis of Cancer.)</i>		Has patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Coma			
Was the patient in a continuous state of unconsciousness for at least 7 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the coma medical induced or the direct result of alcohol or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(Please attach copies of medical records documenting diagnosis.)</i>			
Complete Loss of Hearing / Sight / Speech			
<input type="checkbox"/> Clinical diagnosis information <i>(Please attach copies of medical records documenting diagnosis)</i>	Is the loss of hearing/sight/speech total and irreversible? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Coronary Artery Disease			
Type of Procedure: <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty or Atherectomy <i>(Please provide operative report.)</i>		Date of Procedure: _____	
End-Stage Renal (Kidney) Failure			
Has the patient undergone peritoneal dialysis on at least a weekly basis? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has a kidney transplant been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(Please attach copies of medical records documenting diagnosis and frequency of dialysis.)</i>			
Heart Attack			
Were there new EKG findings consistent with myocardial infarction? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did the patient show elevation of cardiac enzymes above standard laboratory levels of normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(Please attach copies of EKG, lab results, and other diagnostic test results.)</i>			

Major Organ Failure		
Has a transplant been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of transplant recommended: <input type="checkbox"/> Kidney <input type="checkbox"/> Heart <input type="checkbox"/> Heart-Lung <input type="checkbox"/> Lung <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas	Date of Procedure: _____ <i>(Please provide operative report.)</i>
Severe Burns		
Third degree burns? <input type="checkbox"/> Yes <input type="checkbox"/> No	Percent of total body surface affected: _____	
<i>(Please attach copies of medical records documenting diagnosis.)</i>		
Stroke		
Have there been documented neurological deficits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have there been confirmatory neuron-imaging studies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(Please attach copies of all documented neurological deficits and confirmatory neuron-imaging studies.)</i>		
Transient Ischemic Attack (TIA)		
Has Stroke prevention treatment been recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was impairment focal and confined to an area of the brain perfused by a specific artery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(Please attach copies of all documented neurological deficits and confirmatory neuron-imaging studies.)</i>		
Attending Physician Signature		
Physician's Name (please print):		Signature:
Tax ID Number:	Phone:	Fax:
Address: Street, City, State, Zip		