MEDICAL ILLNESS CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

PLEASE READ BEFORE COMPLETING THIS FORM

The furnishing of this form is for the convenience of the policyholder and is not an acknowledgement of liability or waiver of any right.

INSTRUCTIONS:

1. Complete Policyholder/Patient Information on this page.
2. Be sure to sign your claim form at the bottom of this page.
3. **If you are filing for disability**, please complete the "Individual Disability Notice of Claim" form.

ADDITIONAL NOTES:

1. Submit all bills related to this claim such as doctor, hospital (must include the number of days confined, if applicable), ambulance, follow-up visits, physical therapy, etc. All bills should be itemized and should include the diagnosis, services rendered, date of service and actual charges for the service.
2. Be sure to include your policy number on all documents.
3. Provide list of physicians seen in last 2 years.
4. Complete HIPAA form

POLICYHOLDER'S INFORMATION

Policyholder Name (Last, first, middle initial)		Policy Number
Address (City, State, Zip Code)	❑Check This Box If This A New Permanent Address	
Social Security Number	Date of Birth	Telephone Number

PATIENT'S INFORMATION

Patient Name (Last, First, Middle Initial)		Social Security Number	Date of Birth	Height and Weight
❑ Male ❑ Female	❑Single ❑ Other ❑Married	Relationship:	❑ Self ❑ Dependent ❑ Spouse ❑ Check if dependent is full-time student	
*If the patient (child) is over age 19 and a full-time student, provide the name of the school being attended:		School's Address _____		

***If you have not previously submitted proof of full-time student status for the period of the medical expenses submitted, you must do so before the claim can be processed.**

What illness was suffered?		On what date did you first notice you were beginning to get sick? (MM/DD/YYYY) ❑ AM ❑ PM	
Have you ever had the same illness before? ❑ Yes ❑ No	If YES, when? (MM/DD/YYYY)	Date you were first treated by a physician for the illness? (MM/DD/YYYY)	
Were you hospitalized? ** ❑ Yes ❑ No	If YES, on what date were you admitted? (MM/DD/YYYY)	On what date were you released? (MM/DD/YYYY)	
Have you had any medical or surgical advice during the past 5 years for any other condition? ❑Yes ❑ No	If YES, for what?	When? (MM/DD/YYYY)	
Physician's Name and Address			
Has any other physician treated you for this illness? ❑ Yes ❑ No	When? (MM/DD/YYYY)		
Physician's Name and Address			

**If you were in the hospital, please attach an itemized statement.

I authorize any hospital, physician, or other person who has attended me or examined me to disclose to my insurer or their duly authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment relative to my person, and to furnish copies of all hospital or medical records. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original. I understand and agree and if payment of benefits to me results in an overpayment, the Company may deduct the amount of the overpayment from future benefit payments.

_____ _____

Signature (If Claim Is For A Minor, Parent Or Legal Guardian Must Sign) Date

Submit Completed Form to:
Claims Department
P.O. Box 925309
Houston, TX 77292-5309
Customer Service Department 1-800-669-9030
manhattanlife.com

MEDILL 0317

ManhattanLife™

Authorization for the Release of Protected Health Information

Patient Name: _____

Social Security Number: _____

Date of Birth: _____

Policy Number: _____

I, _____, hereby authorize _____'s designated medical custodians or database custodians to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the person(s) or organization(s):

Name of Person(s) or Organization(s):

(Company Name)
10777 Northwest Fwy
P.O. Box 925309
Houston TX 77292-5309

I specifically authorize the use and disclosure of the following PHI:

_____
_____
_____
_____

(Specifically describe the protected health information to be disclosed. Include meaningful descriptors such as date of service, type of service provided, level of detail to be released, etc.)

This protected health information is being used or disclosed to carry out treatment, payment, and/or the _____'s internal operations in the following manner:

_____
_____
_____
_____

(Specifically describe how protected health information will be used to carry out treatment, payment, or the company's internal operations purposes.)

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand and agree that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notice to the company. A revocation is not effective except to the extent that the company has relied on the use or disclosure of the PHI (protected health information).
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The company will not condition my treatment, payment, and enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.
- I have the right to refuse to sign this authorization form.

_____
Signature

_____
Date

_____

_____
Description of Personal Representative's Authority

ManhattanLife™

Manhattan Life Insurance Company
Family Life Insurance Company
Western United Life Assurance Company
ManhattanLife Assurance Company of America

Worksite Benefits
Claims Department
P.O. Box 925309
Houston, Texas 77092-5309

Authorization to Obtain and Disclose Protected Health Information and Other Information

Name: _____ Policy No: _____
I authorize the release and disclosure of my protected health information and other information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider or health care facility to which this authorization is directed to disclose or furnish to the Company(ies) identified above, hereinafter called the Company including any legal representative designated by the Company, the following protected health information: Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents. This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse treatment or services or mental health care to the extent permitted by law.

I further authorize any employer to which this authorization is directed to disclose or furnish my employment, financial and wage information to the Company and any legal representative that it might designate.

I authorize the Company to use or disclose this protected health care information, in connection with payment or health care operations, to any person or entity performing a business or legal function on behalf of the Company or as otherwise specifically permitted or required by law. I understand that information disclosed to, or by, the Company pursuant to this authorization might be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect the payment of claims; (3) I have the right to revoke this authorization at any time by writing to the Company at the address listed at the top of this form; and (4) I should sign both copies of the authorization provided, retaining one copy for my records.

This authorization is valid for up to 12 months from the date it was signed. Revocation of this authorization will not affect the rights of any person or entity who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

_____ _____

Date Authorization Signed

Signature of Claimant or Authorized Personal Representative
(e.g., parent or guardian, if minor)

10777 Northwest Freeway, Suite 600
Houston, TX 77092
www.manhattanlife.com

Phone: 713-529-0045
Toll Free: 800-669-9030

Authorization for Policyholder Initiated Request for Release of Protected Health Information to Other

Name or Employer	Policy Number

Primary Policyholder Covered by the Health Plan (Last, First)

Name of Person Granting Authorization (Last, First) Leave blank if same as Primary Member	Relationship to Primary Policyholder (self, spouse, dependent child or designated personal rep)

My protected health information is information about me that was collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; Iii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

For my purposes and at my request, I authorize Manhattan Life Insurance Company, Family Life Insurance Company, Western United Life Assurance Company and ManhattanLife Assurance Company of America to disclose my protected health information to the following Individual, organization, or class of persons (e.g., group Individuals within the organization) (check all that apply):

❑ My Spouse: (specify)
The protected health information that may be used and disclosed to my Spouse is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status or Protected Health Information related to Claims Status
- ❑ Other (specify) _____

❑ My Employer/ Plan Sponsor:
The protected health information that may be used and disclosed to my Employer/Plan Sponsor is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status
- ❑ Other (specify) _____

❑ Agent: (specify)
The protected health information that may be used and disclosed to my Broker is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status
- ❑ Other (specify) _____

❑ Other: (specify) _____
The protected health information that may be used and disclosed to this specified Individual(s) is as follows (check all that apply):
- ❑ Eligibility
- ❑ Explanation of Benefits
- ❑ Claims Status
- ❑ Other (specify) _____

[If choosing "Other", describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

I understand that I may refuse to sign this authorization. I further understand that the above named health plan will not condition enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to the above named health plan at the address located below, and this revocation will be affective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that the above named health plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the above named health plan and, by law, the above named health plan has a right to contest the coverage.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires at the earlier of: 1) 12 months from the date when it was signed or 2) when I am no longer an active policyholder of the above named health plan.

_____
Signature of Person Granting Authorization or Personal Representative

_____
Date

Printed Name_____
(Last) (First)

_____
Description of Personal Representative's Authority (if applicable)

You may contact me at the address below if you have questions concerning my responses in the Authorization

_____
Street Address City State

Phone: (_____) _____

Email: _____

Send your completed authorization or notice of revocation to the following address:
Claims Department
P.O. Box 925309, Houston, Texas 77092-5309
or
FAX to (713) 583-8508

NOTE: All authorizations granted by this document are in addition to any uses and disclosures of protected health information permitted or required under the Health Insurance Portability and Accountability Act of 1996 and its implementing privacy regulations.

This form is not to be used for obtaining records from providers for underwriting or risk rating.