Liberty Bankers®
Insurance Group | *Liberty Bankers Life*

Administrative Address
PO Box 224, Brownwood, Texas 76804-0224
Toll-Free (800) 604-8002
Claims Fax (325) 643-4043
Claims Email: supphealthclaims@lbig.com

CANCER, HEART ATTACK, AND STROKE POLICY CLAIM FORM

PART ONE

Section A. General Instructions

- To prevent delays, please ensure all applicable sections of the form are completed and provide supporting documentation from your healthcare provider.
- Please review your policy for specific benefits covered under your plan.
- Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere.
- Claim forms and supporting documentation can be submitted via fax **(325) 643-4043** or email **supphealthclaims@lbig.com.** Emailing documents can facilitate in quicker claim processing.

Section B. Insured Information

FIRST	MI	LAST	POLICY NUMBER
STREET ADDRESS			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP	PHONE NUMBER ( )
EMAIL ADDRESS			

Section C. Covered Person or Dependent Incurring Illness

FIRST	MI	LAST	DATE OF BIRTH
SOCIAL SECURITY NUMBER		RELATIONSHIP TO POLICYHOLDER	

Section D. Claimant Statement

DESCRIBE THE NATURE OF THE ILLNESS:

DATE ILLNESS DIAGNOSED

Cancer including Non-Malignant Melanoma Skin Cancer ☐ Yes ☐ No

Please provide a pathology report confirming a diagnosis of cancer by a certified pathologist. If pathology report not available, provide other supporting medical documentation to confirm cancer diagnosis.

Heart Attack ☐ Yes ☐ No

Please provide medical records documenting abnormal electrocardiographic (EKG) results consistent with evidence of a heart attack.

Coronary Angioplasty ☐ Yes ☐ No
Coronary Bypass Surgery ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Please provide medical records documenting neurological deficits lasting for at least ninety-six (96) hours and imaging studies showing brain tissue damage.

PART TWO

Section A. Physician Information (Please use attached Provider Information sheet to list contact information for additional providers you have been treated by over the past 10 years.)

Treating Physician	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	
Primary Physician	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	
Hospital Admission	Yes No		
Treating Hospital:			
Address:	City:	State:	ZIP:
Telephone:	Admission date: _____ / _____ / _____	Discharge date: _____ / _____ / _____	

PART THREE

Section A. Acknowledgment

I hereby certify that the information I have provided in support of this claim is complete and true to the best of my knowledge. I have read the fraud notice, applicable to my state, included with this form. I have also read, signed, and dated the included Authorization to Release Confidential Medical Information. Liberty Bankers Life Insurance Company and I agree that this document may be electronically signed.

Insured's Signature: _____ Date: _____

Signature of Covered Person or Dependent Incurring Accident: _____ Date: _____

(Not required for minors under age 18)

STATE FRAUD NOTICES

AK - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AL – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR and CA – 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.

AZ – 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.

CO – 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 with 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 with the department of regulatory agencies.

DC – 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, any insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

DE – 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.

FL – 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.

ID – Any person, who knowingly and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

IN – Any 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.

LA and WV - 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.

ME, TN, VA and WA: 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 denial of insurance benefits.

MD – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in any application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OH – 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.

OK – 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.

PA – 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.

TX - Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

All Other States – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

HIPAA COMPLIANT AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Records and Information obtained will be disclosed to:

Liberty Bankers Life Insurance Company
PO Box 224, Brownwood, TX 76804-0224

The purpose of this disclosure is to evaluate claim benefits. I hereby authorize you to release any and all records and information within your possession, custody or control regarding the patient pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of the patient's physical or mental condition are to be released. Such medical and non-medical records and information to be released may include, but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKGs.

I, the undersigned, hereby authorize any and all medical practitioners, physicians and pharmacists, pharmacy benefit managers, health care clearing houses, hospitals, clinics, nurses, or records custodians to release any and all records and information regarding the patient named below. I hereby waive all provisions of law forbidding the disclosure of such information.

NAME OF PATIENT	OTHER NAMES USED BY PATIENT
PATIENT'S DATE OF BIRTH	PATIENT'S SOCIAL SECURITY NUMBER

The aforementioned medical information is to be released from: _____ and exchanged between the Insurance company first named above and:

COVENTBRIDGE
9485 Regency Square Blvd Ste 200
Jacksonville FL 32225

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when the patient's medical and non-medical records are disclosed pursuant to this Authorization, the patient's medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. I hereby authorize any medical practitioner, physician, hospital, clinic, pharmacy benefit manager or other medical related facility, insurance support organization to provide to Liberty Bankers Life Insurance Company ("Liberty Bankers") or to any medical record retrieval services acting on Liberty Bankers' behalf. It is understood the Liberty Bankers underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such information to the aforementioned parties for purposes of this claim. This Authorization will remain in effect a maximum of six (6) months from the date of my signature below. I understand that I may revoke this Authorization at any time by requesting such of COVENTBRIDGE or Liberty Bankers in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original. I understand that if I refuse to sign this Authorization to release the patient's complete medical records, my insurance company may not be able to process my claim for benefits and may not be able to make any benefit payments or claim payments. Liberty Bankers Life Insurance Company and I agree that this document may be electronically signed.

Signature of patient/guardian
personal representative: _____

(If patient is a minor, must be signed by a parent. If patient is deceased, must be signed by a spouse/legal next of kin or informant listed on the death certificate.)

Legal relationship to patient: _____

Signed this, the _____ day of _____ in the year _____

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PROVIDER INFORMATION SHEET

Please provide us with the contact information for all medical providers that have treated you for any condition within the past 10 years. This includes Primary Care Physicians (PCP), specialists, hospitals, and pharmacies.

Name	Address	Phone	Fax
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Liberty Bankers Life Insurance Company and I agree that this document may be electronically signed. I hereby certify that the information provided above is true and correct to the best of my knowledge. I understand that knowingly providing any false or misleading information may subject me to criminal or civil penalties.

Insured Signature _____ Date _____