Family Heritage Life Insurance Company of America

P.O. Box 470608 Cleveland, Ohio 44147

Please read the following information before completing this form.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive 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.

Arkansas, Louisiana, Rhode Island, Texas and West Virginia: 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.

Alaska: 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.

Arizona: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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 for the 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 within the department of regulatory agencies.

District of Columbia: 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, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly or 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.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

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

Indiana: 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.

Kentucky: Any person who knowingly or with intent to defraud any insurance company or other person files a 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.

Maine: 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 a denial of insurance benefits.

Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

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

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

Ohio: 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.

Oklahoma: 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.

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

Pennsylvania: 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.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147, (440) 922-5151

HEART AND ICU CLAIM FORM

Instructions:
1. Have the claimant answer all questions, sign and date SIDE 1.
2. Have the treating physician complete SIDE 2.

If filing a **heart claim** submit one claim form for each hospital admission along with all itemized hospital bills, bills from the doctor or surgeon, and diagnostic reports showing the diagnosis of heart disease, heart attack, or stroke.

If filing an **intensive care claim** submit one claim form for each hospital admission along with a copy of the itemized hospital bill listing the intensive care charges and an ambulance bill, if applicable.

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1. Policyowner's name: _____ 2. Policy number: _____

3. Claimant's name: _____ 4. SSN: _____

5. Address: _____

6. Phone #: _____ 7. Date of birth: _____

8. Relation to Policyowner: ❑ Self ❑ Spouse ❑ Son ❑ Daughter ❑ Other _____

9. Describe illness/injury: _____

10. Date first consulted physician: _____ 11. Date diagnosed: _____

12. Has the claimant ever had this condition before? ❑ YES ❑ NO If YES, when? _____

13. List all treating physicians (Include name and phone #): _____

_____

_____

14. Name and phone # of family physician: _____

15. If Hospitalized, when? From: _____ To: _____ Hospital phone #: _____

16. Hospital name: _____
City State

17. Have you ever filed a claim for this condition with Family Heritage? ❑ YES ❑ NO

IMPORTANT NOTICE: Any person who, knowingly facilitates a fraud or has intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements may be guilty of insurance fraud.

AUTHORIZATION MUST BE SIGNED BEFORE A CLAIM CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the MIB, Inc. to furnish any information with respect to any illness or accident, medical history or medical records for the Patient to Family Heritage Life Insurance Company of America (Family Heritage) or its representative for the purpose of evaluating claims for benefits. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to Family Heritage. If I do revoke this authorization, it will not have any affect on any information released before Family Heritage's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I or my authorized representative may request to see and copy the information described in this authorization and that I am entitled to a signed copy of this authorization. I acknowledge that unless an earlier date is specified under applicable law, this authorization will expire 90 days from the date signed.

Signed _____ Date _____
Patient, Parent (If Child) or Executor

IF THE CLAIMANT IS UNABLE TO PROVIDE A SIGNATURE, PLEASE INCLUDE A COPY OF A POWER OF ATTORNEY, LETTER OF EXECUTOR AND/OR DEATH CERTIFICATE.

SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

Patient's Name: _____ Policy Number:_____

1. Has the patient **ever** been diagnosed with or treated for heart disease, a heart attack, or stroke? ❑ YES ❑ NO

   If YES, date of first diagnosis: _____ Date of first treatment: _____

2. List Diagnosis Code(s): A) _____ B) _____ C) _____

3. List reason for hospitalization: _____

4. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO

   If YES, when? _____

5. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

   If YES, name & address of facility: _____

   Date admitted: _____ Date discharged: _____

6. List any applicable surgical CPT procedure codes: A) _____ B) _____ C) _____

7. List any other applicable procedure codes: A) _____ B) _____ C) _____

8. List any specific dates of Intensive Care Unit confinement: _____

9. Do you have records of the patient's past medical history? ❑ YES ❑ NO

10. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Physician's Information:

Physician's Name: _____

Specialty: _____

Address and phone number: _____

Completed by (please print): _____ Position/Title: _____

Physician's Signature: _____ **Date:** _____