UnitedHealthcare

Claim Forms and Instructions for Group Critical Illness

This claim form should be used with plans that may include Child Critical Illness, Additional Critical Illness, or Partial Benefit Critical Illness plan options.

Employer

Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing the employee's request for benefits.**

As the employer, you are required to include the following documentation (as applicable):

- ☐ Enrollment Form (if employee contributes to premium)
- ☐ Copy of approved medical evidence of insurability, if required at the time of enrollment
- ☐ Documentation of earnings – provide 3 months of payroll records

Completed form should be sent directly to UnitedHealthcare Specialty Benefits:

Mail:
UnitedHealthcare Specialty Benefits
PO Box 31328
Salt Lake City, UT 84131-0321

Email (email is unsecured unless you are a registered Cicso user):
FPCustomerSupport@uhc.com

Phone:
800-539-0038

Fax:
888-505-8550

TO BE COMPLETED BY EMPLOYER

General Demographics

INFORMATION ABOUT THE COVERED EMPLOYEE			
Employee's Name:	Social Security Number:		Date of Birth:
Address:	City:	State:	Zip Code:
Location/Division:	Insurance Class:	Date of Hire:	Effective Date of Coverage:
Employee Contribution to premium: ◯ Yes* ◯ No *If EE paid please provide enrollment card	If Yes: ◯ Pre-tax ◯ Post-tax	If Post-tax: % paid by employer % paid by employee	
Employee's Occupation:	Employee's Work Status: ☐ Exempt ☐ Non Exempt ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temporary	Regular scheduled hours per week	
Elected Critical Illness Benefit Amount $	Salary Period (check one): ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly Premium Per Pay Period :		

EMPLOYER INFORMATION			
Employer's Name (name of policyholder, if other)			Group Policy Number
Employer's Address	City	State	Zip Code

Final Signature and Certification

Name of person completing this form	E-mail address	
Title	Phone number	Ext
Signature (eSignature is allowed)	Date Signed	

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com
Mail: PO Box 31328 Salt Lake City UT 84131-0321

Claim Forms and Instructions for Group Critical Illness Employee

Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing your request for benefits.**

As the employee, you are required to include/complete the following documentation (as applicable):

- ☐ Employee Critical Illness Statement
- ☐ Provide a copy of the completed Employee's Disclosure Authorization
- ☐ Provide Attending Physician's Statement to the physician(s) treating you
- ☐ Provide a copy of the completed Employee's Authorization of Personal Representative *(if applicable)*

Completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits:

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UnitedHealthcare Specialty Benefits
PO Box 31328
Salt Lake City, UT 84131-0321

Email (email is unsecured unless you are a registered Cisco user):
FPCustomerSupport@uhc.com

Phone: 800-539-0038

Fax: 888-505-8550

Employee Critical Illness Statement

TO BE COMPLETED BY EMPLOYEE

Please indicate what critical illness benefit you are claiming below:

Critical Illness Category	Check Box	Child Critical Illness Category	Check Box
Benign Brain Tumor	☐	Cerebral Palsy	☐
Cancer (Invasive)	☐	Cleft Lip/Palate	☐
Cancer (Non-Invasive)	☐	Cystic Fibrosis	☐
Chronic Renal Failure	☐	Down Syndrome	☐
Coma	☐	Muscular Dystrophy	☐
Coronary Artery Disease	☐	Spina Bifida	☐
Heart Attack	☐		
Heart Failure	☐		
Major Organ Failure	☐		
Permanent Paralysis	☐		
Ruptured Aneurysm	☐		
Stroke	☐		

INFORMATION ABOUT THE COVERED EMPLOYEE:				
Full Name (First, Last, Middle Initial):			Social Security Number:	Date of Birth:
Address:	City:	State:	Zip Code:	Employer's Name/Group or Policy Number (if known)
Your Occupation:			Last Day Worked:	
Is claim for Insured Employee or Dependent? (Please check one) ◯ Insured Employee ◯ Spouse ◯ Child				

INFORMATION ABOUT THE CLAIMANT:				
Claimant's Name (if other than insured employee) if not the Employee:				Social Security Number:
Address:	City		State:	Zip Code:
Date of Birth:	Height:	Weight:	Gender: ◯ M ◯ F	Date first noticed symptoms of illness/injury:
Describe in detail, the nature of and the onset of illness:				
Date first treated for illness?	Date you were diagnosed with this illness?	Have you ever had the same or a similar condition in the past? ◯ Yes, When?		◯ No

Provide the names, addresses and date you first saw the doctor(s) who are treating you now and/or have treated you for a similar condition in the past. If more space is needed, please attach additional paper.

Physician Name	Phone No.: Fax No.:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ◯ Yes ◯ No
Physician Name	Phone No.: Fax No.:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ◯ Yes ◯ No
Physician Name	Phone No.: Fax No.:	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ◯ Yes ◯ No

Were you admitted to the hospital as part of your treatment? ◯ Yes ◯ No If you answered Yes, please provide information below.			
Hospital Name:		Date of Admission:	Date of Discharge:
Address	City	State	Zip Code
Phone No.:	Fax No:		

CLAIMANT OR BENEFICIARY SIGNATURE (if under 18, signature of parent or guardian is required)

Final Signature and Certification

The above statements are true and complete to the best of my knowledge and belief.
I acknowledge that I have read the applicable Fraud Warning Notice provided with this claim form.

Name of person completing this form	Phone Number
Signature (eSignature is allowed)	Date Signed

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Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com
Mail: PO Box 31328 Salt Lake City UT 84131-0321

(Rev 05/2021)

DISCLOSURE AUTHORIZATION – Supplemental Health **TO BE COMPLETED BY EMPLOYEE**

Participant's Name _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome). If my Plan Administrator sponsors both a supplemental health plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or supplemental health benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, employee/employment records, earnings or finances, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 12 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

PLEASE SIGN AND DATE IN INK

Relationship, if other than Claimant: _____

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Mail: PO Box 31328 Salt Lake City UT 84131-0321

(Rev 10/2020)
UA 10.2020

AUTHORIZATION OF PERSONAL REPRESENTATIVE **TO BE COMPLETED BY EMPLOYEE**

At my request, and for my convenience, I, _____ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my critical illness claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

Date: ____/____/_____

Signature: _____

PLEASE SIGN AND DATE IN INK

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Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com
Mail: PO Box 31328 Salt Lake City UT 84131-0321

CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

UnitedHealthcare

INSTRUCTIONS: PLEASE COMPLETE THE APPROPRIATE SECTION FOR THE CONDITION FOR WHICH YOU ARE TREATING THIS PATIENT AND ENCLOSE THE INFORMATION REQUESTED IN THAT SECTION. ATTACH ADDITIONAL SHEETS IF NECESSARY. IF THERE IS MORE THAN ONE CRITICAL ILLNESS (DIAGNOSIS), PLEASE USE A SEPARATE FORM FOR EACH.

PATIENT INFORMATION

PATIENT'S NAME	DATE OF BIRTH	PATIENT'S DATE OF DEATH (IF APPLICABLE)

WHAT IS THE CURRENT CRITICAL ILLNESS (DIAGNOSIS)?	ICD-10 CODE	DIAGNOSIS DESCRIPTION (INCLUDING COMPLICATIONS)

HAS THE PATIENT EVER RECEVIED MEDICAL ADVICE FOR THIS CONDITION OR A RELATED CONDITION? ☐ YES; WHEN _____ ☐ NO

HAVE YOU ADVISED YOUR PATIENT TO CEASE WORK ACTIVITIES AS A RESULT OF THIS CONDITION? ☐ YES; DATE OF ADVISEMENT _____ ☐ NO

IF YES, PLEASE PROVIDE PHYSICIAN'S NAME AND CONTACT INFORMATION:_____

BENIGN BRAIN TUMOR

DATE OF CONFIRMED DIAGNOSIS: _____ CIRCLE ONE: PATHOLOGICALLY DIAGNOSED OR NEURORADIOLOGICAL EXAM; SPECIFY TYPE: _____

CANCER/CARCINOMA IN SITU

DATE OF CONFIRMED DIAGNOSIS: _____ CIRCLE ONE: PATHOLOGICALLY DIAGNOSED OR CLINICALLY DIAGNOSED
(DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WAS DIAGNOSED)

IF THE CANCER/CARCINOMA WAS PATHOLOGICALLY DIAGNOSED, PLEASE ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

CHRONIC RENAL FAILURE

DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS? ☐ YES ☐ NO

DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (at least weekly) OR WHICH RESULTS IN PLACEMENT ON THE UNITED NETWORK OF ORGAN SHARING (UNOS) TRANSPLANT LIST? ☐ YES ☐ NO

COMA

PLEASE NOTE THAT COMA MUST PERSIST FOR A CONTINUOUS PERIOD OF AT LEAST 14 DAYS.

DATE OF COMA DIAGNOSIS: _____ DURATION OF COMA: _____

PLEASE DOCUMENT SIGNIFICANT MEDICAL INTERVENTIONS AND LIFE SUPPORT MEASURES: _____

_____

PLEASE INDICATE WHETHER COMA IS SECONDARY TO ANY OF THE FOLLOWING CONDITIONS:

☐ STROKE ☐ INJURY ☐ MEDICALLY INDUCED ☐ DRUG OR ALCOHOL USE

CORONARY ARTERY DISEASE

DATE OF RECOMMENDATION FOR SURGERY TO OPEN NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH CORONARY BYPASS GRAFTS (arterial or venous), BALLOON ANGIOPLASTY, LASER ANGIOPLASTY, ATHERECTOMY OR PLACEMENT OF A STENT: _____

OR

DATE OF RECOMMENDATION FOR SURGERY TO OPEN NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH CORONARY BYPASS GRAFTS (arterial or venous), BALLOON ANGIOPLASTY, LASER ANGIOPLASTY, ATHERECTOMY OR PLACEMENT OF A STENT WAS NECESSARY AND RECOMMENDED IF THE PATIENT WAS WELL ENOUGH TO UNDERGO PROCEDURE: _____

HEART ATTACK

DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOIWNG CRITERIA:

1. ARE ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH NEW AND ACUTE MYOCARDIAL INFARCTION? ☐ YES ☐ NO
   PLEASE ATTACH A COPY OF THE EKG'S AND REPORTS.
2. WERE SPECIFIC CARDIAC MARKERS ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL? ☐ YES ☐ NO
   PLEASE ATTACH A COPY OF THE LAB REPORT.
3. DID THE DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ☐ YES ☐ NO
   PLEASE ATTACH COPIES OF ANY APPLICABLE REPORT.
4. DID THE PATIENT HAVE SYMPTOMS CONSISTENT WITH MYOCARDIAL INFARCTION? ☐ YES ☐ NO
   DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION) _____

HEART FAILURE

DATE OF CONFIRMATION OF HEART FAILURE DIAGNOSIS: _____

DATE PLACED ON THE UNITED NETWORK OF ORGAN SHARING (UNOS) TRANSPLANT LIST: _____

IS PATIENT A CANDIDATE FOR THE RECOMMENDED PROCEDURE? ☐ YES ☐ NO

CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

MAJOR ORGAN FAILURE

LIMITED TO LUNG, PANCREAS OR LIVER

DATE OF CONFIRMATION OF MAJOR ORGAN FAILURE DIAGNOSIS: _____ ORGAN IMPACTED (circle involved organs): LUNG PANCREAS LIVER

DATE PLACED ON THE UNITED NETWORK OF ORGAN SHARING (UNOS) TRANSPLANT LIST: _____

IS THE PATIENT A CANDIDATE FOR THE RECOMMENDED PROCEDURE? ☐ YES ☐ NO

PERMANENT PARALYSIS

DID THE PATIENT SUFFER TOTAL AND PERMANENT LOSS OF THE USE OF TWO OR MORE LIMBS (arms or legs or a combination) DUE TO A SICKNESS FOR A CONTINUOUS PERIOD OF AT LEAST 30 DAYS WHICH IS NOT THE RESULT OF OR DUE TO A STROKE OR INJURY? ☐ YES ☐ NO

RUPTURED ANEURYSM

LIMITED TO CEREBRAL, CAROTID, THORACIC AORTIC OR ABDOMINAL AORTIC

DATE OF CONFIRMED DIAGNOSIS: _____ TYPE OF ANEURYSM: _____

STROKE

DID THE PATIENT HAVE A STROKE, MEANING A CEREBROVASCULAR EVENT RESULTING IN MEASURABLE PERMANENT NEUROLOGICAL DAMAGE OR IMPAIRMENT INCLUDING INFARCTION OF BRAIN TISSUE, HEMORRHAGE AND EMBOLISM FROM AN EXTRACRANIAL SOURCE? ☐ YES ☐ NO

STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERERBROBASILAR ISCHEMIA.

DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? ☐ YES ☐ NO

PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE VIA ONE OF THE FOLLOWING DIAGNOSTICS: COMPUTED AXIAL TOMOGRAPHY (CT SCAN) REPORT, MAGNETIC RESONANCE ANGIOGRAPHY (MRA) REPORT, MAGNETIC RESONANCE IMAGING (MRI) REPORT, POSITRON EMISSION TOMOGRAPHY (PET) REPORT OR AN ARTERIOGRAPHY/ANGIOGRAPHY REPORT.

CHILD CRITICAL ILLNESS CATEGORIES*

CEREBRAL PALSY

PEDIATRICIAN (Specialist in neurodevelopmental disorders) OR BOARD CERTIFIED NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: _____ PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF DEVELOPMENTAL SCREENING EVALUATIONS OR ANY ADDITIONAL DIAGNOSTICS THAT MAY HAVE BEEN PERFORMED.

DATE OF CONFIRMED DIAGNOSIS: _____ DESCRIPTION OF CLEFTING (circle one): UNILATERAL BILATERAL

PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ANY PRENATAL ULTRASOUNDS.

CYSTIC FIBROSIS

LICENSED PEDIATRICIAN OR PULMONOLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: _____ SWEAT CHLORIDE CONCENTRATION: _____

PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ALL DIAGNOSTIC REPORTS TO INCLUDE BUT, NOT LIMITED TO SWEAT CHLORIDE CONCENTRATION TESTING, CHEST X-RAYS, SINUS X-RAYS, LUNG FUNCTION TESTING OR SPUTUM CULTURE.

DOWN SYNDROME

LICENSED PEDIATRICIAN OR PHYSICIAN FAMILIAR WITH DOWN SYNDROME DIAGNOSIS SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: _____ PLEASE PROVIDE MEDICAL RECORDS WITH COPIES OF DIAGNOSTIC TEST RESULTS TO INCLUDE BUT NOT LIMITED TO, ANY PRENATAL EVALUATION. IF AVAILABLE, INCLUDE DIAGNOSTIC TEST RESULTS (AMNIOCENTESIS, CHRONIC VILLUS SAMPLING AND CORDOCENTESIS/PERCUTANEOUS UMBILICAL BLOOD SAMPLING/PUBS).

FOR DIAGNOSIS RENDERED AFTER BIRTH, PLEASE INCLUDE PHYSICAL AND/OR DEVELOPMENTAL EVALUATIONS.

MUSCULAR DYSTROPHY

PHYSICIAN FAMILIAR WITH THE DIAGNOSIS AND/OR TREATMENT OR NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: _____ PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ALL DIAGNOSTIC REPORTS TO INCLUDE ELECTROMYOGRAPHY AND MUSCLE BIOPSY RESULTS.

SPINA BIFIDA

PHYSICIAN FAMILIAR WITH THE DIAGNOSIS AND/OR TREATMENT SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS: _____ PLEASE PROVIDE MEDICAL RECORDS TO INCLUDE COPIES OF ALL DIAGNOSTIC REPORTS. IF DIAGNOSIS WAS MADE DURING PREGNANCY, INCLUDE DIAGNOSTIC TEST RESULTS INCLUDING ULTRASOUND REPORTS, AMNIOCENTESIS AND/OR MATERNAL SERUM ALPHA FETOPROTEIN (MSAFP) TEST.

**In California, a signature by a Physician who is qualified in the applicable filed of Medicine is acceptable. Not available in Colorado.*

ADDITIONAL CRITICAL ILLNESS CATEGORIES

AMYOTROPHIC LATERAL SCLEROSIS

BOARD CERTIFIED NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS ACCORDING TO MUSCULAR DYSTROPHY ASSOCIATION (MDA) CRITERIA: _____

CURRENT STAGE ACCORDING TO MDA CRITERIA (circle one): ☐ EARLY ☐ MIDDLE ☐ LATE

COMPLETE BLINDNESS

LICENSED OPTHALMOLOGIST SIGNATURE REQUIRED

DATE THAT DIAGNOSIS WAS CONFIRMED: _____

CORRECTED VISUAL ACUITY: LEFT EYE _____/_____ RIGHT EYE _____/_____

VISUAL FIELD SEVERITY: LEFT EYE _____/_____ RIGHT EYE _____/_____

CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

COMPLETE LOSS OF HEARING

AUDIOLOGIST OR PHYSICIAN SIGNATURE REQUIRED

DATE THAT DIAGNOSIS WAS CONFIRMED: _____ IS HEARING LOSS TOTAL AND PERMANENT? ☐ YES ☐ NO
AUDITORY THRESHOLD (frequency of 500-4000 cycles): LEFT EAR _____ RIGHT EAR _____

ADVANCED ALZHEIMER'S

BOARD CERTIFIED NEUROLOGIST SIGNATURE REQUIRED

DATE THAT DIAGNOSIS WAS CONFIRMED: _____
PATIENT REQUIRES SUBSTANTIAL ASSISTANCE IN PERFORMING THE FOLLOWING ACTIVITIES OF DAILY LIVING (circle all that apply): ○
BATHING ○ CONTINENCE ○ DRESSING ○ EATING ○ TOILETING ○ TRANSFERRING

ADVANCED MULTIPLE SCLEROSIS

BOARD CERTIFIED OR BOARD ELIGIBLE NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS USING McDONALD CRITERIA FOR CLINICAL DIAGNOSIS: _____

ADVANCED PARKINSON'S

BOARD CERTIFIED OR BOARD ELIGIBLE NEUROLOGIST SIGNATURE REQUIRED

DATE OF CONFIRMED DIAGNOSIS USING STANDARD STAGING CRITERIA FOR CLINICAL DIAGNOSIS: _____
CURRENT CLINICAL STAGE (circle one): ○ ONE ○ TWO ○ THREE ○ FOUR ○ FIVE
IS THIS DIAGNOSIS SECONDARY TO ANY OF THE FOLLOWING CONDITIONS (circle all that apply): ○ PROGRESSIVE SUPRANUCLEAR PALSY ○ CORTICOBASAL DEGENERATION ○ MULTIPLE SYSTEM ATROPHY ○ VASCULAR PARKINSONISM ○ DEMENTIA WITH LEWY BODIES

PARTIAL BENEFITS CRITICAL ILLNESS CATEGORIES

ADDISON'S DISEASE (ADRENAL HYPOFUNCTION) DATE OF CONFIRMED DIAGNOSIS: _____	LEGIONNAIRES DISEASE DATE OF CONFIRMED DIAGNOSIS: _____	OSTEOMYELITIS DATE OF CONFIRMED DIAGNOSIS: _____
AMYOTROPHIC LATERAL SCLEROSIS (LOU GHERIG'S DISEASE) DATE OF CONFIRMED DIAGNOSIS: _____	MALARIA DATE OF CONFIRMED DIAGNOSIS: _____	POLIOMYELITIS DATE OF CONFIRMED DIAGNOSIS: _____
CEREBROSPINAL MENINGITIS (BACTERIAL) DATE OF CONFIRMED DIAGNOSIS: _____	MULTIPLE SCLEROSIS (DEFINITIVIE DIAGNOSIS) DATE OF CONFIRMED DIAGNOSIS: _____	RABIES DATE OF CONFIRMED DIAGNOSIS: _____
CYSTIC FIBROSIS DATE OF CONFIRMED DIAGNOSIS: _____	Is this a Clinically Isolated Syndrome (CIS)? ☐ Yes ☐ No	SICKLE CELL ANEMIA (EXCLUDING SICKLE CELL TRAIT) DATE OF CONFIRMED DIAGNOSIS: _____
DIPTHERIA DATE OF CONFIRMED DIAGNOSIS: _____	MUSCULAR DYSTROPHY DATE OF CONFIRMED DIAGNOSIS: _____	SYSTEMIC SCLEROSIS (SCLERODERMA) DATE OF CONFIRMED DIAGNOSIS: _____
ENCEPHALITIS DATE OF CONFIRMED DIAGNOSIS: _____	MYASTHENIA GRAVIS DATE OF CONFIRMED DIAGNOSIS: _____	TETANUS DATE OF CONFIRMED DIAGNOSIS: _____
HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA) DATE OF CONFIRMED DIAGNOSIS: _____	NECROTIZING FASCIITIS DATE OF CONFIRMED DIAGNOSIS: _____	TUBERCULOSIS DATE OF CONFIRMED DIAGNOSIS: _____
SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) DATE OF CONFIRMED DIAGNOSIS: _____ TYPE OF LUPUS (circle one): ○ SYSTEMIC ○ CHRONIC CUTANEOUS/DISCOID ○ SUBACUTE CUTANEOUS ○ TIMID ○ DRUG-INDUCED		

OCCUPATIONAL HIV INJURY

DATE THAT DIAGNOSIS WAS CONFIRMED: _____ DATE OF INITIAL HIV ANTIBODY TEST: _____ RESULTS:
DATE OF FOLLOW-UP HIV ANTIBODY TEST (90-180 DAYS AFTER INJURY): _____ RESULTS:
PLEASE PROVIDE A COPY OF EACH TEST RESULT

ATTENDING PHYSICIAN'S SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE DESCRIBED INFORMATION IS BASED UPON REASONABLE MEDICAL PROBABILITY AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

NAME (ATTENDING PHYSICIAN) PLEASE PRINT	DEGREE/SPECIALTY REQUIRED	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
SIGNATURE eSignature is allowed	DATE	MEDICAL ID#	

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Fax: 888 505 8550 Unsecured E-mail: FPCustomerSupport@uhc.com
Mail: PO Box 31328 Salt Lake City UT 84131-0321

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Alabama:
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 for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

For claimants in 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.

For claimants in 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.

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

For claimants in 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.

For claimants in Connecticut:
Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Delaware:
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.

For claimants in 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.

For claimants in Florida:
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

For claimants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For claimants in 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.

For claimants in Indiana:
A 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.

For claimants in Kansas:
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 may be guilty of fraud as determined by a court of law.

For claimants in Kentucky:
Any person who knowingly and 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.

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in 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.

For claimants in Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

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

For claimants in 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.

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

For claimants in New Mexico:
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 civil fines and penalties.

For claimants in 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.

For claimants in Oklahoma:
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For claimants in Oregon:
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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in Tennessee 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.

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

For claimants in Vermont:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:
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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:
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.

PO Box 31328 Salt Lake City, UT 84131-0321
Tel 888 299 2070
Fax 888-505-8550

Claims Department
Direct Deposit Agreement
For Payment of Benefit to Financial Institution

Section 1 (to be completed by benefit recipient)

Name of Benefit Recipient

UHCSB Claim Number

UHCSB Policy Number

Social Security Number

Telephone Number

Address (Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

"I authorize UnitedHealthcare Specialty Benefits to direct the net amount of my benefit payment to be deposited directly by electronic funds transfer and credited to my account as indicated at the financial institution designated below. If any payments made are dated after the date of my death, I hereby authorize and direct the said financial institution on my behalf and on behalf of my executors or administrators to refund any such payments to UnitedHealthcare Specialty Benefits and to charge the same to my account."

Signature of Benefit Recipient (eSignature is allowed)

Date Signed

Section 2

Name of Financial Institution

Address ((Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

Routing Number (9 digit number in lower left corner of check)

Bank Account Number (numbers following the Routing Number)

Type of Account ☐ Checking ☐ Savings (check one)