



Mail to: Colonial Life & Accident Insurance Company  
PO Box 100195  
Columbia SC 29202-3195

Fax to: 1-800-880-9325  
If you fax your claim, do not mail the original document but keep it for your records.

Your claim must be filed within 12 months of your date of loss.

Please check the type of claim you are filing below:

- Wellness-** See top of page 3.
- Cancer Policy-** See below.
- Routine Pregnancy-** See page below if you are filing for benefits for normal post-delivery disability. Pages 4 and 5 are not necessary.
- Total Disability-** (Accident/Sickness/Pregnancy complications) Section B contains parts for both your employer and doctor to complete. See pages 4 and 5.
- Accidental Injury-** Section C, page 5, requests specific information from you about the circumstances of your injury.
- Hospital Confinement, Intensive Care or Outpatient Surgery-** Have your doctor complete Section D, page 6, and send copies of your hospital or outpatient surgery bills.

If you have any questions while completing this claim form, please call us at 1-800-325-4368. We will assist you with the information and forms needed.

### CANCER

If you do not have a cancer policy, please complete the sections that apply to your coverage. To file for benefits under a cancer policy, please complete page 3 and check **cancer** at the top of this page:

- For *Internal Cancer* – Attach a copy of the **pathology report** from your *initial* diagnosis.
- Attach copies of itemized statements for all medical expenses incurred relating to the diagnosis and treatment of your malignancy. Please clearly write your name and social security number on each bill.
- For *Skin Cancer* – Attach a copy of your pathology report for *each date of service* a lesion was biopsied and/or removed.
- *Transportation and Lodging* – Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.
- **If you are claiming disability, please have your employer and doctor complete SECTION B.**

### To be completed and signed by your doctor

#### A. ROUTINE PREGNANCY (6 weeks for vaginal delivery or 8 weeks for c-section, less the elimination period)

If disabled due to complications of pregnancy, before or after delivery, complete **Section B on page 4**.

Date of Delivery (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Type delivery: Vaginal / C-Section (circle one)

Date you first treated patient for this pregnancy (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of Hospital Confinement (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Hospital: \_\_\_\_\_ Hospital Phone Number: (\_\_\_\_) \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

Treating Doctor's Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Mailing address \_\_\_\_\_

CLAIMANT NAME: **X** \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

If you wish to file a **Wellness/Cancer Screening claim for a test performed within the past 12 months**, you need the name and date of the test performed as well as your doctor's name and phone number. We also need to know if this is for you or another covered individual and their name and social security number. You may:

- **FILE BY PHONE!** Call 1-800-325-4368 and provide the information requested by our Automated Voice Response System, 24 hours per day, 7 days a week, or
- **SUBMIT ON THE INTERNET** using the Wellness Claim Form at [www.coloniallife.com](http://www.coloniallife.com), or
- Write your name, address, social security number and/or policy/certificate number on your bill and indicate "Wellness Test." **FAX** this to us at **1-800-880-9325** or **MAIL** to PO Box 100195, Columbia SC 29202.

*If your Wellness/Cancer Screening test was more than one year ago, you must fax or mail us a copy of the bill or statement from your doctor indicating the type of procedure performed, the charge incurred and the date of service. Please write your full name, social security number, and current address on the bill.*

**Please note: If your cancer policy includes a second part to the screening benefit**, bills for tests covered and a copy of the diagnostic report (reflecting the abnormal reading of your first test) must be mailed or faxed to us for benefits to be provided.

This claim is for:  Self  Spouse  Dependent: if over 18, name of school \_\_\_\_\_

Name of Claimant \_\_\_\_\_ Name of Policyholder (if not claimant) \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Policy Number: \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street (Apt. #) City State Zip

(must include street address for overnight delivery)

**Has your address changed since we last heard from you?**  YES  NO

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Fax Number: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

If you are claiming disability, please list the dates you were unable to work: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please print INFORMATION ABOUT YOUR DOCTOR(S) AND/OR HOSPITAL**

*Please continue on a separate sheet if necessary. Be sure to include any referring physician(s).*

<b>Full name of treating doctor</b>
Mailing Address
City State Zip Code
(____) (____)
Phone number Fax number
Email

<b>Full name of primary doctor</b>
Mailing Address
City State Zip Code
(____) (____)
Phone number Fax number
Email

<b>Full name of referring doctor/hospital</b>
Mailing Address
City State Zip Code
(____) (____)
Phone number Fax number
Email

<b>Other</b>
Mailing Address
City State Zip Code
(____) (____)
Phone number Fax number
Email

**CERTIFICATION**

**Policyholder/Employee's Name** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

I have checked the answers on this claim form and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I acknowledge that I received the "Claim Form Addendum: Fraud Warning and State Versions" form and that I read the statement required by the State Department of Insurance for my state, if my state was listed on the form.

PLEASE ALSO SIGN AND DATE THE ATTACHED AUTHORIZATION.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  PATIENT SIGNATURE  POLICYHOLDER/EMPLOYEE SIGNATURE

CLAIMANT NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**B. DISABILITY BENEFITS. To be completed and signed by the DOCTOR treating you for this disability:**

Diagnosis/ primary disabling condition/ ICD9 Code(s): \_\_\_\_\_

Secondary conditions contributing to this disability: \_\_\_\_\_

Would the patient be disabled without regards to these secondary conditions?  yes  no

Has this patient been treated for same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment: \_\_\_\_\_

Is this condition the result of an accidental injury?  yes  no If yes, please provide us with the date and description. \_\_\_\_\_

Dates of Inpatient Hospital Confinement: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital: \_\_\_\_\_  
Name Address

List any surgeries performed and submit a copy of the operative report. \_\_\_\_\_

Is this patient permanently disabled?  yes  no If yes, what are the permanent restrictions/limitations? \_\_\_\_\_

How soon do you expect significant improvement in the patient's medical condition? \_\_\_\_\_ # weeks/months (circle one)

Dates unable to work: Full Duty: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates unable to work: Partial Duty: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

List Restrictions/Limitations preventing work \_\_\_\_\_

Is this patient considered to be house confined (unable to perform normal daily activities) or unable to perform 2 or more activities of daily living? Yes / No (circle one) If yes, which ADLs cannot be performed? \_\_\_\_\_

For what period? From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_  
(This information will be used in accordance with state regulations and policy provisions.)

Anticipated return to work/release date: \_\_\_\_\_ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

If due to complications of pregnancy prior to delivery, what is EDC? \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of office visits (mm/dd/yyyy): \_\_\_\_\_

Recommended frequency of treatment: \_\_\_\_\_

Signature of doctor: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient #: \_\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

Full name of referring doctor \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

**NOTE: Please make a copy of the patient's signed authorization to release information for your records.**

CLAIMANT NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**To be completed and signed by your EMPLOYER:**

Name of Employer: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Employee working at any other place of employment? \_\_\_\_\_ Employee's Job Title: \_\_\_\_\_

yes  no If yes, where \_\_\_\_\_

Dates this employee has been unable to work:

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To: \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm

From: \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm To: \_\_\_\_/\_\_\_\_/\_\_\_\_ am/pm

Date employee returned to main or principal duties:

\_\_\_\_/\_\_\_\_/\_\_\_\_  Part time \_\_\_\_\_ Number of hours/week  
 Full time

Date employee returned to light duty: \_\_\_\_/\_\_\_\_/\_\_\_\_

Monthly salary \$ \_\_\_\_\_ Hourly salary \$ \_\_\_\_\_

Did the accident occur while working for wage/profit?

yes  no If yes, list date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has Workers' Compensation been approved?  yes  no

Name and address of Workers' Compensation carrier:

Is modified or light duty available?  yes  no If yes, date available. \_\_\_\_\_

Signed: **X** \_\_\_\_\_ Title: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

(To be signed by your employer)

**C. ACCIDENTAL INJURY-** please complete and attach itemized copies of any related bills including doctor, ambulance, emergency room, and hospital. Bills should include diagnosis information (from your medical provider).

Date of accident (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of accident: \_\_\_\_\_ am / pm (circle one)

Tell us how your accident happened:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you at work, working for wage or profit, at the time of your accident?  yes  no

Have you ever had a similar injury? \_\_\_\_\_ If so, please tell us when (mm/dd/yyyy): \_\_\_\_\_

**If you are claiming disability, please have your employer and doctor complete SECTION B.**

CLAIMANT NAME: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**D. HOSPITAL CONFINEMENT, INTENSIVE CARE OR OUTPATIENT SURGERY BENEFITS.** Please send an itemized copy of your hospital bill which includes the *diagnosis, admission and discharge dates*. Have your doctor complete this section if your bills do not include diagnosis information. Please send a copy of the anesthesiologist bill if outpatient surgery was performed.

Diagnosis/ICD-9 Code: \_\_\_\_\_

Dates of Inpatient Hospital Confinement: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates of Confinement in Intensive Care, including Coronary Care Unit: From \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Hospital Address: \_\_\_\_\_

Date of Surgery (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Inpatient / Outpatient (circle one) Procedure/procedure code: \_\_\_\_\_

Date of office visit following confinement or outpatient surgery (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of doctor: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_ Tax ID or SSN: \_\_\_\_\_

***If you are claiming disability, please have your employer and doctor complete SECTION B.***

