



**HEALTH SCREENING AND WELLNESS CLAIM FORM**

**INSTRUCTIONS**

**Health Screening or Wellness Claim**

If you are filing for the health screening or wellness benefit, complete the first three lines of the Policyholder/Claimant Information section and the Health Screening Information section. Attach documentation indicating the type of test performed, the date the test was performed, and the charges incurred. Please read the authorization section and sign in the space provided. Failure to sign the authorization will delay the processing of your claim.

**Send all claims to:**      **Continental American Insurance Company**  
**Claims Processing Unit**  
**Post Office Box 427**  
**Columbia, South Carolina 29202**  
**800-433-3036**

POLICYHOLDER/CLAIMANT'S INFORMATION				
POLICYHOLDER'S NAME	POLICY/CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX
POLICYHOLDER'S ADDRESS			POLICYHOLDER'S TELEPHONE NO.	
CLAIMANT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	CLAIMANT'S DATE OF BIRTH	SEX	
HEALTH SCREENING OR WELLNESS INFORMATION				
WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:				
<input type="checkbox"/> STRESS TEST ON A BICYCLE OR TREADMILL	<input type="checkbox"/> FASTING BLOOD GLUCOSE TEST	<input type="checkbox"/> MAMMOGRAPHY		
<input type="checkbox"/> SERUM CHOLESTEROL TEST (HDL AND LDL)	<input type="checkbox"/> BONE MARROW TESTING	<input type="checkbox"/> BLOOD TEST FOR TRIGLYCERIDES		
<input type="checkbox"/> CA 15-3 (BLOOD TEST FOR BREAST CANCER)	<input type="checkbox"/> CA 125 (BLOOD TEST FOR OVARIAN CANCER)	<input type="checkbox"/> BREAST ULTRASOUND		
<input type="checkbox"/> CHEST X-RAY	<input type="checkbox"/> COLONOSCOPY	<input type="checkbox"/> CEA (BLOOD TEST FOR COLON CANCER)		
<input type="checkbox"/> HEMOCULT STOOL ANALYSIS	<input type="checkbox"/> THERMOGRAPHY	<input type="checkbox"/> FLEXIBLE SIGMOIDOSCOPY		
<input type="checkbox"/> PSA (BLOOD TEST FOR PROSTATE CANCER)	<input type="checkbox"/> SERUM PROTEIN ELECTROPHORESIS (MYELOMA)	<input type="checkbox"/> PAP SMEAR		
		<input type="checkbox"/> OTHER		
IF OTHER, PLEASE SPECIFY THE TYPE OF TEST PERFORMED:				
DATE THE HEALTH SCREENING TEST WAS PERFORMED				
AUTHORIZATION				
Several states require that the following statement appear on the claim forms:				
<b>Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.</b>				
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.				
Policyholder's Signature: _____		Date: _____		
Claimant's Signature: _____		Date: _____		

INSURED: \_\_\_\_\_ CLAIM #: \_\_\_\_\_ COVERAGE ID: \_\_\_\_\_

**AUTHORIZATION FOR CONTINENTAL AMERICAN INSURANCE COMPANY**

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

**Disclosure of Health Information**

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran’s Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.

I am the individual to whom this authorization applies or that person’s legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

\_\_\_\_\_  
(Printed name of individual subject to disclosure)

\_\_\_\_\_  
(Date of Birth)

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

\_\_\_\_\_  
(Date Signed)

If applicable, I signed on behalf of the insured as \_\_\_\_\_ (indicate relationship) if legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

\_\_\_\_\_  
(Printed name of legal representative)

\_\_\_\_\_  
(Signature of legal representative)

\_\_\_\_\_  
(Date Signed)

**PRE-EXISTING INVESTIGATION STATEMENT**

**If you are filing during the first year of your coverage effective date and subject to a pre-existing investigation, complete the below pre-existing statement form in full and return to our office with your claim form. *You will need to provide medical information for the 12 month period PRIOR to your effective date of coverage.***

**CLAIMANT NAME:** \_\_\_\_\_

**COVERAGE ID #:** \_\_\_\_\_

**REQUIRED DOCTOR INFORMATION**

DOCTORS NAMES	ADDRESS	TELEPHONE NUMBER	REASON FOR TREATMENT	DATES

**REQUIRED HOSPITAL INFORMATION**

NAME OF HOSPITAL	ADDRESS	TELEPHONE NUMBER	REASON	DATES

**PRESCRIPTION MEDICATIONS**

NAME OF MEDICINE	PRESCRIBING DOCTOR	PHARMACY NAME, ADDRESS AND TELEPHONE NUMBER	REASON FOR MEDICATION

**MAJOR MEDICAL CARRIER**

NAME OF CARRIER	ADDRESS & TELEPHONE NUMBER	POLICYHOLDER NAME	POLICY NUMBER

**\*\*PLEASE ATTACH ADDITIONAL PAPER IF NEEDED\*\***

Should you need additional information or instruction on completing this form, please call our Customer Service Department @ 1-800- 433-3036.

**Signature and Date:** \_\_\_\_\_