SUPPLEMENTAL MEDICAL EXPENSE (GAP) CLAIM FORM

Companion Life

MAIL TO: SPECIAL INSURANCE SERVICES, INC.
PO BOX 250349
PLANO, TX 75025-0349
(800) 767-6811 – phone; (214) 291-1301 – fax
Email: customerservice@specialinc.com

CHECKLIST

1. Complete STATEMENT OF INSURED below, answering all questions fully.
2. **ATTACH EXPLANATION OF BENEFITS (EOB) provided by the insurer for your Comprehensive Major Medical Plan, if applicable, to this claim form.**
3. Return this claim form, all itemized bills and EOBs to the address shown above.

STATEMENT OF INSURED

Your Name	☐ Male ☐ Female	Date of Birth
Policy Number	Social Security Number	Telephone Number
Your Address (Number and Street)	City	State Zip Code
Name of Patient		Date of Birth

Relationship to Insured: ☐ Self ☐ Son ☐ Spouse ☐ Daughter

Does Patient have a Medicare Health Insurance Claim Number (HICN)? ☐ Yes ☐ No — If "Yes", please provide HICN #:

Describe Injury or Sickness Completely *(If injury, describe how accident occurred)*

Date of Injury or Beginning of Sickness:

Name and Address of Physician Who First Treated This Condition — Date First Treated

Is Injury or Sickness Due to Employment? ☐ Yes ☐ No

Will You or Your Dependent File for Workers' Compensation? ☐ Yes ☐ No

Are you or your dependent covered under any other insurance plan (including Blue Cross & Blue Shield), Student Accident, Hospital Indemnity or Governmental Plan? ☐ Yes ☐ No

If "Yes", please specify insurance carrier's name, address, policy number and daily benefit amount, if applicable, for any other insurance plan that you currently have, or any plan that has terminated since the effective date of your coverage under Hospital Confinement Indemnity plan.

Name of Company	Address	Coverage Type	Policy Number	Benefit Amount	Termination Date

NOTE TO ALL PARTIES COMPLETING THIS FORM: 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.

*****NOTICE – See State Specific Fraud Notices on Next Page*****

I certify that the information given by me in support of this claim is true and correct.

► _____ _____

Insured's Signature Date

IMPORTANT! PLEASE COMPLETE THE AUTHORIZATION INCLUDED WITH THIS FORM

Companion Life

c/o SPECIAL INSURANCE SERVICES, INC. • P.O. BOX 250349 • PLANO, TX 75025-0349
800-767-6811 • FAX 214-291-1301 • EMAIL customerservice@specialinc.com

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

I authorize the disclosure of health information regarding, or related to:

Name: _____ Date of Birth _____ Policy No. _____
Claim No. _____

- I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This Authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.
- I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this Authorization does not authorize the release of psychotherapy notes.
- I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.
- I authorize Companion Life Insurance Company, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this Authorization.
- The purpose of the disclosure authorized herein is to permit Companion Life Insurance Company, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to administer the above-referenced individual's health insurance coverage.
- This Authorization shall expire twenty-four (24) months after the date on which it is executed below.
- I understand that eligibility for the health plan is conditioned on my execution of this Authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations.
- I understand that I may revoke this Authorization by sending written notice of my intent to revoke this Authorization to Companion Life Insurance Company c/o Special Insurance Services, Inc. P.O. Box 250349, Plano, TX 75025-0349.
- I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.
- A copy or facsimile of this Authorization shall be as valid as the original.

_____ _____
Signature of the individual or the individual's personal representative Date

_____
If signed by the individual's personal representative (e.g. a parent on behalf of a child), describe your authority to sign on behalf of the individual

FRAUD WARNING NOTICES: (If the Applicant lives in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Alabama/Arkansas/ Louisiana	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.
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 certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder 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 regulatory agencies.
DC	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 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.
Kentucky/Ohio	I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.
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 denial of insurance benefit.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico/ 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.
Oklahoma	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.
Tennessee	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.
All Other States	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.