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 #): ______________________

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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:** ____________