Beazley Insurance Company, Inc.
Administrative Services provided by:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: 800-508-9238
aciclaims@acitpa.com
Fax: 610-293-9299

Critical Illness Claim Form

INSTRUCTIONS – PLEASE READ CAREFULLY:

- **Section 1A through 1E: To be completed and signed by claimant/insured.**
- **Section 2A & 2B: To be completed and signed by attending physician.**
- **Section 3: To be completed and signed by employer's authorized representative.**
- **Please submit completed form to the address listed above.**

SECTION 1A: CLAIMANT INFORMATION

Last Name	First Name	M.I.	Date of Birth
Relationship to Insured:	Insured Name:		
Street Address Apt. No.	City	State	Zip Code
Home Phone: ( )	Work Phone: ( )	E-Mail Address:	
Group Name:	Group Number:	Your Occupation:	

SECTION 1B: TYPE OF ILLNESS

Check type of Specified Disease for which claim is being made: ☐ Cancer ☐ Heart Attack ☐ Stroke ☐ Coma ☐ Coronary Artery Bypass ☐ Loss of Sight ☐ Occupational HIV ☐ Organ Transplant ☐ Paralysis ☐ Renal Failure ☐ Severe Burns

If injury, please describe date and nature of injury:

SECTION 1C: PHYSICIAN INFORMATION *(To be completed by claimant/insured.)*

Complete only if claim is being made within the first 12 months of the policy effective date. Please attach a separate sheet if additional space is needed.

List all the physicians who have treated the patient within the past 12 months:

Physician's Name:

Street Address Apt. No. City State Zip Code

Approximate Date Consulted:

Diagnosis / Treatment / Medication:

Physician's Name:

Street Address Apt. No. City State Zip Code

Approximate Date Consulted:

Diagnosis / Treatment / Medication:

SECTION 1D: SIGNATURE *(This form must be signed.)*

AUTHORIZATION AND ACKNOWLEDGMENT

I certify that the above information is true and correct to the best of my knowledge and belief.

X ______________________________ ______________________________ ______________________

Signature of Claimant Relationship to Insured Date Signed

SECTION 1E: AUTHORIZATION TO RELEASE INFORMATION ***(This section must be signed.)***

I, the undersigned authorize any hospital or other medical-care institution, physician or other medic al professional, pharmacy, insurance support or, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representative, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose, death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol to determine eligibility for benefit payments under the Policy Number identified above. I authorized the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

X ______________________________________ ______________________

Signature of Claimant Date Signed

SECTION 2A: ATTENDING PHYSICIAN'S STATEMENT

Patients Name:	Date of Birth:	Date of Death (if applicable):
Date Signs or Symptoms Appeared:	The patient has received treatment for this or a similar condition: ☐Yes/When:_______☐No	

Diagnosis:	Date of Diagnosis:

PLEASE COMPLETE THE APPROPRIATE SECTION:

CANCER

Date of Diagnosis: *(The date the pathological specimen(s) were obtained on which the cancer was diagnosed.)*	Stage:	Cancer Diagnosed: ☐ Pathologically ☐ Clinically
Pathology Report Attached: ☐ Yes ☐ No ☐ Not Applicable *(If the cancer was pathologically diagnosed, attach a copy of the pathology report.)*	Medical Evidence Attached: ☐ Yes ☐ No ☐ Not Applicable	
Reason Pathological Diagnosis Not Obtained: *(If the cancer was clinically diagnosed, please provide the reason that a pathological diagnosis was not obtained and attach medical evidence that supports the diagnosis of cancer.)*		

HEART ATTACK

New and serial Electrocardiographic (EKG) findings are consistent with myocardial infarction: ☐ Yes ☐ No	EKGs & Report(s) Attached: ☐ Yes ☐ No
Cardiac enzymes were elevated above generally accepted laboratory levels of normal in cases of creatine physphokinase (CPK): ☐ Yes ☐ No	Lab Report Attached: ☐ Yes ☐ No *(A CPK-MB measurement must be used, attach a copy of the lab report.)*
Imaging studies such as thallium scans, MUGA scans, or stress echocardiograms were used to confirm the diagnosis: ☐ Yes ☐ No	Applicable Report(s) Attached: ☐ Yes ☐No
The patient had chest pain consistent with myocardial infarction: ☐ Yes ☐ No	Date of Diagnosis: *(The date the patient met all of the above criteria for heart attack.)*

STROKE

The patient had a stroke (apoplexy) due to: ☐ Rupture ☐ Acute Occlusion of Cerebral Artery ☐ Cerebral Vascular Accident or Incident

Stroke does not include:
☐ Head Injury ☐ Transient Ischemic Attacks ☐ Chronic Cerebrovascular Insufficiency ☐ Attacks of Vertebrobasilar Ischemia

COMA

The patient was in a state of unconsciousness for at least 14 consecutive days during which no reaction to external stimuli was seen and no reaction to internal needs were noted: ☐ Yes ☐ No

Life Support Required: ☐ Yes ☐ No	Respiratory Intubation Required: ☐ Yes ☐ No

CORONARY ARTERY BYPASS

The patient underwent open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, at the advice of a Physician board certified in cardiology: ☐ Yes ☐ No	Operative Report Attached: ☐ Yes ☐ No

LOSS OF SIGHT

The patient has irreversible loss of sight in both eyes: ☐ Yes ☐ No

Explain the patient's corrective visual acuity in both eyes:

Corrective visual acuity is greater than 20/200 in both eyes or is the field of vision less than 200 in both eyes: ☐ Yes ☐ No

OCCUPATIONAL HIV	
HIV was caused from an injury which occurred at work and exposed the insured to HIV-contaminated body fluids: ☐ Yes ☐ No	
ORGAN TRANSPLANT	
The patient was a recipient of a: ☐ Human Heart ☐ Lung ☐ Liver ☐ Kidney ☐ Pancreas	
If so, please attach a copy of the operative report.	Operative Report Attached: ☐ Yes ☐ No
Condition that caused the need for the organ transplant:	Date the patient was first seen for this condition:
PARALYSIS	
The patient lost complete and permanent loss of function of two or more limbs for a continuous period of at least 90 days: ☐ Yes ☐ No	
Diagnosis: (paralysis excludes loss of function following a stroke):	Date of Complete and Permanent Loss:
The patient did recover functionality: ☐ Yes ☐ No	If yes, Duration of the Condition:
RENAL FAILURE	
The patient has end stage Renal Failure presenting as chronic, irreversible failure of both kidneys to function: ☐ Yes ☐ No	
The patient requires weekly: ☐ Renal Dialysis ☐ Hemodialysis ☐ Peritoneal Dialysis (*Treatment can be more frequently than weekly but must be at least weekly.)*	
The rental failure resulted in a kidney transplantation: ☐ Yes ☐ No	Date of Diagnosis: *(The date a doctor or physician recommends that the patient begin dialysis.)*
The cause of the patient's renal disease:	Date the patient was first treated for signs or symptoms of this condition:
SEVERE BURNS	
The patient has third degree burns covering at least 20% of the surface area of his body: ☐ Yes ☐ No	
Complete Diagnosis:	Date the patient was first treated for this condition:

SECTION 2B: ATTENDING PHYSICIAN'S SIGNATURE *(This section must be signed)*

Printed Name of Physician:		Tax ID:
Street Address Apt. No. City State Zip Code		
Phone Number: ( )	Fax Number: ( )	E-Mail Address:

I hereby certify that the above information is true and correct to the best of my knowledge.

X ______________________________ ____________________

Authorized Employer Signature Date Signed

SECTION 3: EMPLOYER STATEMENT *(This section must be signed)*

Employer Name:		Group Number:
Name of Authorized Person:		Title:
Street Address Apt. No. City State Zip Code		
If Branch or Affiliate, Name of Parent Company:		Employer Social Security or Tax ID Number:
Phone Number: ( )	Fax Number: ( )	E-Mail Address:
Employee Name:	Employee Date of Birth:	Employee Social Security Number:
Employee Job Title:	Date of Employment:	Insurance Effective Date:

I hereby certify that the above information is true and correct to the best of my knowledge.

X ______________________________ ____________________

Authorized Employer Signature Date Signed

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

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.

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.

Arkansas, Louisiana, Rhode Island, West Virginia - 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.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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.

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.

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.

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.

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.

Kansas – It is unlawful to commit a fraudulent insurance act, which means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine, Tennessee, Virginia, 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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.

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

New Mexico – Any person who, with intent to defraud or knowing that he or she 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.

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.

Oklahoma - WARNING: 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 is guilty of a felony.

Oregon - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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.

Vermont - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.