LifeMap® | P.O. Box 1271, M/S E8L
Portland, OR 97207

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free 1 (800) 286-1129
Fax (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Individual Critical Illness and Emergency Treatment Benefit Claim Form

Claim Filing Instructions

This Individual Critical Illness and Emergency Treatment (ICIET) Claim Form includes the forms required to apply for ICIET benefits.

If a form is received incomplete, unsigned or undated, it will be returned to you for completion, delaying the claim.

Instructions:

1. Answer all questions on the **Individual Critical Illness and Emergency Treatment Benefit Claim Form** in full. (pages 2 & 3)
2. Sign and date the **Authorization**. (page 5)
3. Have your provider complete and sign the **Attending Physician's Statement.** (page 6)

You are responsible for ensuring all forms are completed and returned to our office. Our review of your claim will not begin until we receive all completed forms.

Forms can be sent to LifeMap via:

Email: **claims@lifemapco.com**

Fax: **1 (855) 733-4615**

Regular Mail: **LifeMap Assurance Company**
Attn: Claims Department
PO Box 1271, M/S E8L
Portland, OR 97207-1271

If you have any questions, please call the LifeMap Claims Department at 1 (800) 286-1129.

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Information regarding the Primary Insured and the Patient

This claim is for ☐ Self ☐ Spouse/Domestic Partner ☐ Dependent Child	Policy Number	
Name of Primary Insured (Last, First, MI)	Social Security Number of Primary Insured	
Home Address & Apt. No./Mailing Address City State Zip		Home Phone Number ( )
Name of Patient (Last, First, MI)	Date of Birth	Relationship to Insured

Information regarding a Critical Illness

Type of Illness:	Date of first treatment: _____/_____/_____

Please describe the symptoms: _____

_____

Has patient ever had this or a similar condition before? ☐ Yes ☐ No If yes, please provide the date: _____/_____/_____

and the name and address of treating physician: _____

_____

Information regarding Emergency Treatment due to an Accidental Injury

Date of Accident	Time of Accident ☐ AM ☐ PM	Was the patient at work when the Accident occurred? ☐ Yes ☐ No

Please describe how the accident happened. (If you need more space, please attach a separate sheet of paper.)

Information regarding Emergency Treatment due to an Illness

Type of Illness:	Date of first treatment: _____/_____/_____

Please attach copies of all itemized bills related to a critical illness or emergency treatment including doctor, emergency room and hospital. Please include the motor vehicle incident/accident report, if applicable.
Additional medical information may be requested to evaluate your claim.

Continued on following page.

Please complete Authorization to Release Information form on page 5.

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Information regarding your Physicians and/or Hospital

Full name of Physician first seen for this condition.		Specialty
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )
Full Name of Primary Physician		Specialty
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )
Full Name of Referring Physician/Hospital		Specialty
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.
I acknowledge that I have read the fraud notice on page 4 of this form.

▶ _____
Primary Insured's Full Name (please print clearly)

▶ _____ ▶ _____
Primary Insured's Signature Date Signed

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Insurance Fraud Warning

Unless specific state language is provided below, the following fraud notice applies: 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.

Arizona Residents: 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.

California Residents: 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 Residents: 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.

District of Columbia Residents: 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.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

New York Residents: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Ohio Residents: 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.

Maine, Tennessee, Virginia and Washington Residents: 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.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: 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.

LifeMap FN V8/14

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Authorization for Release of Information

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

Persons or Institutions: This authorizes you to give LifeMap Assurance Company (LifeMap), its representatives, or persons performing business or legal services on behalf of LifeMap any information, data or records you have regarding my medical history and treatment (including records pertaining to psychiatric, drug or alcohol use, relating to sexually transmitted diseases or HIV/AIDS testing information and any medical condition I may now have or have had), and any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, state disability, earnings and employment history needed to evaluate my claim for disability benefits.

I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing LifeMap to assist with this purpose. This authorization is valid for the duration of my claim. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

▶ _____ ▶ _____

Patient's Full Name (please print clearly) Date Signed

▶ _____ ▶ _____

Patient's Signature (or Parent/Guardian) Relationship to Patient

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Attending Physician's Statement

Please answer all questions and attach copies of confirming diagnostic reports

Primary Insured Name	Policy Number
Patient Name	Date of Birth

Diagnosis and concurrent conditions (Include ICD9 Codes):

Date symptoms first appeared: _____/_____/_____	Date patient first consulted you: _____/_____/_____
Is this condition due to an accidental injury? ☐ Yes ☐ No	Is this condition due to the patient's employment? ☐ Yes ☐ No

Has patient ever had the same or a similar condition: ☐ Yes ☐ No If yes, provide brief details including dates of treatment: _____

_____

Has patient been hospitalized as a result of this condition? ☐ Inpatient ☐ Outpatient ☐ Not at all

If hospitalized, date of admission: _____ Date of discharge: _____

Hospital Name and Complete Address: _____

_____

Have you treated this patient for other conditions? ☐ Yes ☐ No

If yes, give dates, diagnosis codes and briefly describe treatment: _____

_____

_____

Is patient currently being treated for this diagnosis or any related diagnosis by any other health care provider? ☐ Yes ☐ No

If yes, please include name, specialty and addresses of other treating health care providers:

_____

_____

Was patient referred to you? ☐ Yes ☐ No If yes, name, specialty and address of referring doctor:

_____

_____

Information about Physician

Physician's Name (Please Print)	Degree/Specialty	Phone Number
Office Address	City State Zip	Fax Number

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 7 of this form.

▶ _____ ▶ _____

Attending Physician's Signature Date

Please return completed form to your patient or fax to our office at 1-855-733-4615.

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