Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Critical Illness Benefit Claim Form

Please type or print legibly.

Employee and Claimant Instructions for filing a Critical Illness Claim

- Answer all questions accurately and thoroughly. Signatures are required in Sections 5 and are also required in Section 3 if requesting payment be made directly into a bank account. Incomplete forms may be returned.
- Your attending physician must complete Section 6 of this form.
- Submit your completed form(s) via one of these methods:
  a) Mail: Nationwide PO Box 1910, Covington, LA 70434
  b) Fax: 985-898-1770
  c) E-mail: service@nebsupport.com
- If you have any questions, please contact Customer Service at (877) 717-4455.

Section 1: Policy and Employer Information

Employer Name	Group Policy Number
Nationwide Insurance	NE00005

Section 2: Employee Information

Employee Name (First, MI, Last)	Date of Birth	Gender: Male ☐ Female ☐
Address (Street Name/Number, City, State, Zip)		
Phone Number	Email Address	

Work Location/Division	Occupation	Social Security Number:
Date of Hire	Critical Illness Benefit Amount Elected:	Effective Date of Insurance

Were you Actively at Work at the time of claim? ☐ Yes ☐ No If yes, hours worked per week: _____
If No, please provide reason and date last worked:

Section 3: Claim Payment Options

Please select one of the following benefit payment options:

☐ **I authorize Nationwide to deposit my benefit claim payment into my personal bank account.** As a convenience to me, I authorize Nationwide Insurance and its authorized representative, HealthComp Holding Company LLC., Covington, LA (TIN #72-0519951), to deposit claim payments and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below.

Bank Name_____ Name on Bank Account_____
Checking ☐ Savings ☐

Please submit ***a voided blank check or a copy of a bank statement, direct deposit authorization form or other documentation showing the routing and account numbers.***

Authorized Signature_____ Date _____

☐ **Please send a lump sum check to me for benefit claim payment.**

Section 4: Claim information

Claimant Name (First, MI, Last)	Date of Birth:	Date of Death (if applicable, please include copy of death certificate)
Address (Street Name/Number, City, State, Zip)		

Relation to Employee	Social Security Number:	Gender
☐ Self ☐ Spouse ☐ Child ☐ Other _____		☐ Male ☐ Female

If spouse, are you divorced or legally separated? ☐ Yes ☐ No If child, is he/she married? ☐ Yes ☐ No

Section 4: Claim information – Continued

Claim is for:

☐ Heart Attack

☐ Minor Coronary Heart Disease (balloon angioplasty or stent)

☐ Major Coronary Heart Disease (bypass/artery grafts, valve replacement)

☐ Stroke

☐ Major Organ Failure

☐ End Stage Renal Failure

☐ Cancer

☐ Advanced Alzheimer's Disease

☐ Advanced Parkinson's Disease

☐ Muscular Dystrophy

☐ Multiple Sclerosis

☐ Motor Neuron Disease

Please provide the date you first ***consulted*** a physician for symptoms related to this illness _____/____/_____

Is this a recurrent diagnosis? ☐ Yes ☐ No If Yes, when were you first ***diagnosed*** for this illness? _____/_____/_____

Please provide the name, address, and phone number for all treating physicians (attach separate piece of paper if needed):

Please provide the name, address and phone number for all hospitals that treated claimant for this illness (attach separate piece of paper if needed):

(New York) 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Section 5: Certification and Signature(s)

I certify that I have read the State Fraud Notices on page 5. I certify that the above information is complete, true, and correctly recorded.

(New York) 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 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.

By signing below, I am providing consent to Nationwide Employee Benefits to receive claim documents and communications electronically. Please refer to the terms and conditions on page 6. If you do not consent to Electronic Delivery of Insurance Documents, please check here ☐.

Employee Signature	Date	Claimant Signature (if other than employee)	Date

Nationwide
is on your side

CRITICAL ILLNESS AUTHORIZATION AND DISCLOSURES

Nationwide Employee Benefits
P.O. Box 1910
Covington, LA 70434

Section 6: To Be Completed by the Claimant or Authorized Representative

TO:

- Physicians and Other Health Care Professionals
- Hospitals, Clinics and Health Care Facilities

You are authorized to provide information related to my health condition to Nationwide® and its authorized representatives as described below.

This form allows the release of the following information, collectively referred to as "Information" which includes records, office notes, test results, diagnostic imaging studies, data, and information about health care history, diagnosis, prognosis, treatment, rehabilitation, vocational testing, examinations, and prescriptions.

I understand that the Information being disclosed may include protected health information under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations (HIPAA), information regarding mental health conditions and the use of drugs or alcohol, and information regarding the human immunodeficiency virus (HIV).

I understand that the Information will be used for the purpose of evaluating, managing and/or administering a critical illness claim, which is an excepted benefit under HIPAA. I further authorize re-disclosure of any Information obtained or developed to reinsurers, claims investigators, attorneys, physician consultants and other service providers, including treating physician(s), solely for the purpose of evaluating, analyzing, managing and/or administering the critical illness claim. I understand that information re-disclosed pursuant to this authorization may not be protected under HIPAA.

I understand that this authorization shall remain in force for a period of 24 months, or such shorter period as mandated by applicable law. I also understand that I have the right upon request to receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid and effective as the original.

I understand that I have the right to refuse to sign this authorization and that this authorization is subject to revocation at any time by my giving written notice that is signed by me to the address above. I understand that any such revocation shall not apply to any disclosure or re-disclosure of Information made in reliance on my initial authorization. I also understand that my failure to sign this authorization, or my subsequent revocation of this authorization, may impair the ability of Nationwide® and its authorized representatives to process my claim and may lead to the denying my claim for benefits.

Print Patient's Full Name: _____ Date of Birth: _____

Patient's Signature: _____

If the patient is a minor or unable to sign, an authorized representative may sign on behalf of the patient.

☐ Patient is a minor: _____ years of age

☐ Patient is unable to sign because: _____

Print Representative Name: _____

Description of Representative's Authority to Sign: _____

Representative Signature: _____ Date: _____

Section 7: Attending Physician Statement *(must be completed by the physician)*

- Answer all questions accurately and thoroughly. Incomplete forms may be returned
- The physician must sign the completed form. If you have questions, please call (877) 717-4455.

Patient's Name	Date of Birth	Social Security # (SSN)

Check all that apply:	**Questions and Medical Documentation Required**
☐ Heart Attack or Myocardial Infarction	1. Is this a new clinical presentation? ☐ Yes ☐ No 2. Did diagnostic studies confirm a myocardial infarction and the occlusion of one or more coronary arteries? ☐ Yes ☐ No If yes, what is the date of diagnosis? _____ If no, please explain: _____ 3. Was there a previous (old) myocardial infarction? ☐ Yes ☐ No If yes, please provide date: _____
☐ Major Coronary Heart Disease (bypass/artery grafts, valve replacement)	1. Is this a new clinical presentation? ☐ Yes ☐ No 2. What surgical procedure was recommended or performed? _____ 3. Date surgical procedure was recommended: _____ 4. What surgical procedure was performed? _____What date was the surgical procedure performed? _____ 5. If there was a previous bypass, artery graft, valve replacement or similar procedure, please provide the prior procedure name and date performed: _____
☐ Minor Coronary Heart Disease (balloon angioplasty or stent)	1. Is this a new clinical presentation? ☐ Yes ☐ No 2. What procedure(s) was/were recommended: _____ 3. Date the procedure(s) was/were recommended: _____ 4. What procedure was performed? _____ 5. What date was the procedure performed? _____ 6. If there was a previous catherization procedure of balloon angioplasty, stent placement or similar procedure, please provide the prior procedure name and date performed. :_____
☐ Stroke	1. The date the patient suffered the cerebrovascular event: _____ 2. Was the stroke diagnosis supported by neuroimaging studies? ☐ Yes ☐ No 3. Did the stroke result in paralysis or other measurable objective neurological deficit that persisted for at least 30 days? ☐ Yes ☐ No If No, please explain: _____ 4. Was the stroke related to a transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency, or reversible ischemic neurological deficits? ☐ Yes ☐ No If Yes, please explain: _____ 5. Has the patient ever received medical advice or treatment for a stroke or a similar condition in the past? ☐ Yes ☐ No If yes, when? : _____
☐ Major Organ Failure	1. Is the organ failure severe enough that it requires the malfunctioning organ(s) or tissue to be replaced with an organ(s) or tissue from a suitable human donor? ☐ Yes ☐ No 2. Type of Transplant (select all that apply): ☐ Heart ☐ Liver ☐ Kidney ☐ Lung ☐ Small Intestine ☐ Pancreas ☐ Bone Marrow: Is the Bone Marrow donor the patient? ☐ Yes ☐ No ☐ Other (please list): _____ 3. What condition caused the need for the organ transplant? :_____ 4. The date the patient was registered by the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP): _____ If the patient is too ill for a transplant, but otherwise meets the criteria for placement on the UNOS or NMDP list, please check here ☐ 5. Date of organ transplant, if applicable: _____
☐ End Stage Renal Failure	1. Does the patient have chronic irreversible failure of both kidneys? ☐ Yes ☐ No 2. What is/are the condition(s) causing the patient's renal disease? :_____ 3. When was the patient first treated for the condition(s) above? :_____ 4. Was renal or peritoneal dialysis recommended? ☐ Yes ☐ No If yes, please indicate the date recommended: _____ 5. Will this condition result in a renal transplant? ☐ Yes ☐ No If applicable, what is the date the patient was registered by the United Network of Organ Sharing (UNOS)? :_____

☐ Cancer	1. Type of cancer diagnosis: _____ 2. Date of Diagnosis: _____ 3. Was cancer pathologically diagnosed? ☐ Yes ☐ No (If yes, attach a copy of pathology report.) 4. Was cancer clinically diagnosed? ☐ Yes ☐ No (If yes, provide reason why pathological diagnosis was not obtained and attach supporting medical evidence for the diagnosis). 5. TMN or equivalent stage: _____, if applicable. 6. Has the patient ever received medical advice or treatment for cancer in the past? ☐ Yes ☐ No If yes, please list type of cancer and date of previous diagnosis:
☐ Alzheimer's Disease	1. Date of the patient's initial Alzheimer's diagnosis: _____ 2. Does the patient exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing? ☐ Yes ☐ No 3. Please check all Activities of Daily Living (ADL's) the patient requires substantial assistance in performing as a direct result of the Alzheimer's diagnosis: ☐ Bathing ☐ Toileting ☐ Dressing ☐ Continence ☐ Eating ☐ None of the above ☐ Transferring 4. If applicable, what is the date the patient was unable to perform at least two ADL's without substantial assistance? :
☐ Parkinson's Disease	1. Date of patient's initial Parkinson's diagnosis: _____ 2. What is the patient's current stage of Parkinson's Disease on the Hoehn and Yahr staging scale? :_____ 3. Please check all Activities of Daily Living (ADL's) the patient requires substantial assistance in performing as a direct result of the Parkinson's diagnosis: ☐ Bathing ☐ Toileting ☐ Dressing ☐ Continence ☐ Eating ☐ None of the above ☐ Transferring 4. If applicable, what is the date the patient was unable to perform at least two ADL's without substantial assistance? :
☐ Motor Neuron Disease	1. Please select patient's diagnosis: ☐ Amyotrophic lateral sclerosis (ALS) ☐ Progressive bulbar palsy or pseudobulbar palsy ☐ Primary lateral sclerosis (PLS) ☐ Other: _____ ☐ Spinal muscular atrophy (SMA) 2. Date of patient's initial diagnosis: _____ 3. Please check all Activities of Daily Living (ADL's) the patient requires substantial assistance in performing as a direct result of the above diagnosis: ☐ Bathing ☐ Toileting ☐ Dressing ☐ Continence ☐ Eating ☐ None of the above ☐ Transferring 4. If applicable, what is the date the patient was unable to perform at least two ADL's without substantial assistance? :
☐ Muscular Dystrophy	1. Date of patient's Muscular Dystrophy diagnosis: _____
☐ Multiple Sclerosis	1. Date of patient's Multiple Sclerosis diagnosis: _____ 2. Please check all Activities of Daily Living (ADL's) the patient requires substantial assistance in performing as a direct result of the above diagnosis: ☐ Bathing ☐ Toileting ☐ Dressing ☐ Continence ☐ Eating ☐ None of the above ☐ Transferring 3. If applicable, what is the date the patient was unable to perform at least two ADL's without substantial assistance? :

Attending Physician's Signature

Physician Name	Specialty/Board Certification	Degree	
Street Address	City	State	Zip code
Signature	Date	Physician EIN	

Please mail, fax, or email the completed form and documentation to:

Nationwide Employee Benefits
P.O. Box 1910
Covington, LA 70434

Fax: (985) 898-1770
Email: service@nebsupport.com

State Fraud Notices

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

(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) Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

(Arkansas) 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 information to obtain or amend insurance coverage or to make a 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) 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.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(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) 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.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

(**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.

(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 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 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 civil fines and criminal penalties.

(New York) 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

(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 any false, incomplete or misleading information is guilty of a felony.

(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.

(Rhode Island) 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.

(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.

(Texas) Any person who knowingly presents a 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.

(Virginia) 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.

(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 include imprisonment, fines and denial of insurance benefits.

(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.

(All Other States) 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/or civil penalties.

Nationwide
is on your side

Terms and Conditions of Electronic Delivery of Insurance Documents

In order for Nationwide Employee Benefits (hereinafter referred to as "we" or "us) to send you your insurance-related documents and communications electronically, to the extent permitted by law, you must first consent to us doing so. The insurance-related documents and communications you will receive in electronic format will have the same contractual force and effect as insurance-related documents and communications sent to you in paper format. We reserve the right, in our sole discretion, to provide any insurance-related documents and communications to you in paper form instead, and / or to discontinue this service or modify the terms of this agreement at our option. If we do, we will provide you with reasonable notice and you will have the option to withdraw your consent at that time.

YOUR CONSENT: By NOT checking the box in Section 5 on Page 2, you:

1. Consent to receive insurance-related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, **as well as termination and cancellation or non-renewal notices**, electronically to the email address you provide to us on the claim form instead of receiving these records in a paper format from **Nationwide Employee Benefits.**
2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law.
3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time the documents are sent, unless Nationwide receives notice that the email notification was not delivered to you at the email address you provided.

YOUR RIGHT TO WITHDRAW YOUR CONSENT: If you consented to receiving insurance-related documents and communications electronically, you may withdraw your consent at any time. After we process your withdrawal of consent, you will begin receiving your insurance documents and correspondence in paper form. To withdraw your consent, please send a written request to Nationwide Employee Benefits, PO Box 1910, Covington, LA 70434.

YOUR RIGHT TO RECEIVE PAPER COPIES: You have the right to obtain paper copies of your insurance-related documents and communications at any time. To obtain paper copies, please contact Nationwide Employee Benefits at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

YOUR OBLIGATIONS: If you consent to receive insurance documents and correspondence electronically, you are responsible for (i) providing Nationwide with an updated and active e-mail address through the contact listed below. You should be diligent in updating your email address with us in the event that your address changes; (ii) maintaining or having access to a computer capable of connecting to the internet; (iii) maintaining internet access; (iv) installing software on your personal computer to receive, access, store, and print in accordance with the Technical Requirements listed below; (v) an email service account that allows you to read, write, and send email; (vi) an active email address

UPDATING YOUR CONTACT INFORMATION: It is your responsibility to provide Nationwide Employee Benefits with a current, valid email address and to promptly update any changes to this information by contacting us at 1-877-717-4455, service@nebsupport.com, or PO Box 1910, Covington, LA 70434.

UNDELIVERABLE AND RETURN EMAILS: Any e-mails returned as undeliverable will result in a suspension of electronic document delivery and a return to paper copies sent via U.S. mail.

TECHNICAL REQUIREMENTS: The following minimal technical requirements are necessary to receive electronic records:

E-Mail – Access to an email account with a provider such as Gmail®, Outlook®, or Yahoo!®
PDF Reader – Acrobat® or similar software may be required to view and print PDF files