MEMBER BENEFITS nysut Working to Benefit You

GROUP CATASTROPHE MAJOR MEDICAL PLAN

Sponsored by NYSUT Member Benefits Catastrophe Major Medical (CMM) Insurance Trust

CRITICAL ILLNESS CLAIM FORM

PLEASE NOTE
USE THIS CLAIM FORM IF THE ORIGINAL DIAGNOSIS OCCURED PRIOR TO JANUARY 1, 2018

- For an original diagnosis occurring prior to January 1, 2014, the CMM Plan Certificate of Insurance (Policy # E-610,219), underwritten by the United States Life Insurance Company in the City of New York, remains in effect.
  Mail your claims to: The United States Life Insurance Company in the City of NY
  P.O. Box 1581, MSN 2-E
  Neptune, NJ 07754-1581
  Questions: 800-348-6908
- For an original diagnosis occurring between January 1, 2014 and December 31, 2017, the CMM Plan Document (Policy # CMMI-002) sponsored by NYSUT Member Benefits Catastrophe Major Medical Insurance Trust is in effect.
  Mail your claims to: Mercer Consumer
  P.O. Box 14437
  Des Moines, Iowa 50306-3437
  Questions: 888-386-9788
- **DO NOT USE THIS FORM** for original diagnosis dates on or after January 1, 2018 regarding CMM Policy # CMMI-004; rather send your claim to HealthSmart (healthsmart.com/nysut or 844-552-7805).

INSTRUCTIONS

1. Complete the Insured/Claimant's Information section. 2. Read and sign the HIPAA Authorization forms and Fraud Statement. The Authorizations will help us obtain any additional information needed to process your claim. Failure to sign the Authorizations will delay the processing of your claim. 3. Have your attending physician complete the Attending Physician's Statement section of this form for the specific critical illness for which the claim is being made. If you are filing for cancer under the critical illness benefit, please attach the pathology report that confirms the diagnosis.

INSURED/CLAIMANT INFORMATION

Name of Insured	Policy # **CMMI-002 E-610,219**	NYSUT ID#	Date of Birth	Gender

Insured's Address, Street & No, City State Zip	Phone

Patient's Name	Relationship to Insured	Patient's Date of Birth

What is the specific Critical Illness for which the claim is being made	When was the Critical Illness first diagnosed	Have you ever had the same or similar condition: ☐ YES ☐ NO

List the name, address, and telephone number for all attending physicians for the Critical Illness (Please attach a separate list if additional space is needed).

If the Critical Illness required hospitalization, provide the name and address of the treating facility (Please attach a separate list if additional space is needed).

IMPORTANT NOTICE: It is unlawful for any person to knowingly, and with the intent to defraud, present, or cause to be presented, or prepare with the knowledge and belief that it will be presented to a self-insurer, a claim for payment, containing any materially false information concerning any material fact related to such claim, or to conceal, for the purpose of misleading, information concerning any material fact related to such claim (collectively, "Unlawful Acts"). Such Unlawful Acts may also lead to a denial of benefits from this Plan.

Participant's Signature: Date: Claimant's Signature: Date:

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	DATE OF BIRTH	DATE OF DEATH (IF APPLICABLE)

WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? ☐ YES, WHEN _____ ☐ NO	DIAGNOSIS (INCLUDING COMPLICATIONS)

CANCER

DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER WAS DIAGNOSED)	WAS THE CANCER/CARCINOMA IN SITU ☐ PATHOLOGICALLY DIAGNOSED OR ☐ CLINICALLY

IF THE CANCER WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

MYOCARDIAL INFARCTION (HEART ATTACK)

DOES THE PATIENTS CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

1.	ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKG'S AND REPORTS.	☐ YES ☐ NO
2.	WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHYSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT.	☐ YES ☐NO
3.	DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.	☐ YES ☐ NO
4.	DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?	☐ YES ☐ NO

DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)

CORONARY ARTERY BYPASS SURGERY

DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.	☐ YES	☐ NO

WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

MAJOR ORGAN TRANSPLANT

DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, KIDNEY, LUNG, LIVER OR BONE MARROW? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.	☐ YES	☐ NO

WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

STROKE

DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTERBROBASILAR ISCHEMIA.	☐ YES	☐ NO
DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN REPORT OR MAGNETIC RESONANCE IMAGING (MRI) REPORT.	☐ YES	☐ NO

DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES)?

QUADRIPLEGIA

DOES THE PATIENT HAVE COMPLETE AND PERMANENT LOSS OF THE USE OF ALL FOUR LIMBS THROUGH PARALYSIS FOR A CONTINUOUS PERIOD OF 180 DAYS OR MORE?	☐ YES	☐ NO

WHAT IS THE CAUSE FOR THE PATIENT'S QUADRIPLEGIA?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

TERMINAL ILLNESS

DOES THE PATIENT HAVE A MEDICAL CONDITION, WHICH IS EXPECTED TO RESULT IN THE PATIENT'S DEATH WITHIN 12 MONTHS AND FROM WHICH THE PATIENT IS NOT EXPECTED TO RECOVER?	☐ YES	☐ NO

WHAT IS THE CAUSE FOR THE PATIENT'S TERMINAL ILLNESS?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

ATTENDING PHYSICIAN'S SIGNATURE

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

NAME (ATTENDING PHYSICIAN) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	

American General
Life Companies

HIPAA Authorization
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give The United States Life Insurance Company in the City of New York and the American General Life Companies LLC, (an affiliated service company), collectively the "Companies", and their authorized representatives, as well as other agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American General Life Companies which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life Companies Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: The United States Life Insurance Company in the City of New York, P.O. Box 1581, MSN 2-E, Neptune, New Jersey 07754. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Insured or Insured's Personal Representative Date

_____

Description of Authority of Personal Representative (if applicable)

American General
Life Companies

FRAUD STATEMENT SECTION

FRAUD WARNING

This fraud warning applies to the CMM Plan Certificate of Insurance (Policy # E-610,219) which remains in effect for benefit period effective dates 12/31/13 or before.

In some states we are required to advise you of the following: any person who knowingly intends to defraud or facilitates a fraud against an insurer by submitting an application or filing a false claim, or makes an incomplete or deceptive statement of material fact, may be guilty of insurance fraud.

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, Maryland, New Mexico, Rhode Island, Texas, 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 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.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding and 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 provided 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, Idaho, Indiana, Oklahoma: WARNING – 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, Maine, Tennessee, Virginia, Washington: WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may 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: 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.
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 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.
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.
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.
Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years.

Signature of Insured

Date

MEMBER BENEFITS
nysut
Working to Benefit You

HIPAA Authorization Section
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give NYSUT Member Benefits Catastrophe Major Medical Insurance Trust ("Trust"), and their authorized representatives, including its administrator, Mercer Consumer, as well as other agents and insurance support organizations, (collectively, the "Recipients"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company;
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipients to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Recipients listed above are subject to federal privacy regulations. I understand that information released to the Recipients will be used and disclosed as described in the Trust's HIPAA Privacy Notice, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipients to contest a claim under the policy or to contest the policy itself, by sending a written request to: Mercer Consumer, PO Box 14437, Des Moines, IA 50306-3437. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipients for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipients may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Claimant or Claimant's Personal Representative — Date

_____

Description of Authority of Personal Representative (if applicable)