BlueCross BlueShield of Montana

Phone Number: (866) 739-4090
Fax: (312) 540-4706

Accelerated Death Claim Form

Return to Blue Cross and Blue Shield of Montana at:
Attention: Claims Department
PO Box 7070
Downers Grove, IL 60515

INSTRUCTIONS

Your Life Insurance policy allows you to apply for an accelerated benefit paid to you during your lifetime if you are determined to have a terminal illness. This benefit is an advance payment of a portion of your Life Insurance, up to the maximum amount indicated in your Life Insurance policy. If your claim is approved and payment is made to you the amount of your Life Insurance under the Group Policy will be reduced by the Benefit paid.

To apply, the Claim packet should be completed in full. Each entry is important and must be completed to avoid delay in processing your claim. If an information block does not apply or if information is not available, please write “none” in the space provided. If a form is incomplete, it will be returned. PLEASE PRINT.

To be eligible for this Benefit, you must meet the following conditions:

- Be insured for Life Insurance under the Group Policy at the time you apply and receive this benefit.
- Provide us with satisfactory written proof from a medical professional that you have a terminal illness.

Please note that you can receive this benefit **only once.**

Your claim packet consists of:

Section 1. Parts A & B, Employee Statement
Section 1, parts A & B are to be completed by the Employee and returned to the Employer to be sent to Blue Cross and Blue Shield of Montana. Remember to sign and date each Statement. Your signature enables BCBSMT to obtain the information necessary to determine your eligibility for this benefit. You may request a copy of this authorization.

Section 2. Employer Statement

To be completed by the Employer and returned to BCBSMT along with Section 1. Sections 1 & 2 should be sent to BCBSMT as soon as they are completed, and the Attending Physician Statement can be sent at a later date.

Section 3. Attending Physician Statement
To be completed by the Employee’s Physician. If you have more than one Physician for your condition, a statement should be completed by each Physician. The completed section of the claim form should be returned to:

Blue Cross and Blue Shield of Montana
Attention Claims Department
PO Box 7070
Downers Grove, IL 60515

The Employee is responsible for ensuring that all required portions of the claim form are completed and returned to BCBSMT. Contact BCBSMT at 1-866-739-4090 for any questions or assistance regarding this claim form packet.

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SECTION 1 - PART A – TO BE COMPLETED BY THE EMPLOYEE

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children and supplemental security income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, you should consult with the appropriate social services agency concerning how receipt will affect your eligibility and/or that of your spouse or dependents.

Receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, you should seek assistance from a qualified tax advisor.

No health care facility as defined in Section 20 of the Public Health Law can require you to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

BCBSMT is prohibited from paying accelerated death benefits to you for a period of 14 days from the date of your application for an Accelerated Death Benefit.

This application is voluntary and without coercion on the part of any third party.

_____ _____
Signature Date

_____
Print Name

Your spouse is required to sign this request if you reside in one of the Following Community Property states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin.

_____ _____
Spouse Signature Date

_____
Print Name

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SECTION 1 PART B – TO BE COMPLETED BY THE EMPLOYEE

Claimant's Name _____ (Last) _____ (First) _____ (Middle)

Date of Birth _____ Social Security No. _____ HT _____ WT _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone _____ E-mail _____

Name of Employer _____ Occupation _____

Maiden Name _____

1. Date of accident or beginning of sickness

2. Are you still working: ☐ Yes ☐ No If No, Date last worked _____

3. Nature of injury or illness

4. If injury, describe how, when and where accident occurred

5. Have you ever had a similar illness: ☐ Yes ☐ No If yes, give dates From _____ To _____

6. Name of Hospital(s) - Attach separate page if necessary

Dates confined
From _____
To _____

Address of Hospital(s)
_____ (Street) _____ (City) _____ (State) _____ (Zip)

7. Name of Doctor(s) - Attach separate page if necessary

Dates of treatment
From _____
To _____

Address of Doctor(s)
_____ (Street) _____ (City) _____ (State) _____ (Zip)

8. If benefits are being claimed for a dependent spouse or child, complete the following

Dependent Name _____ Social Security Number _____

Date of Birth _____ Gender _____ Relationship _____

9. Benefits being claimed

Amount of Life Insurance Inforce $ _____

Amount of Benefit Requested $ _____

Remaining Life Insurance $ _____

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Section 2 : EMPLOYER'S/PLAN ADMINISTRATOR'S STATEMENT

Group Name _____ Group Number _____

Employee's Name _____ (Last) _____ (First) _____ (Middle) _____ (Social Security No.)

Hire Date _____ Insured Effective Date _____

Employer's Address

_____ (Street) _____ (City) _____ (State) _____ (Zip)

Employer's E-mail Address _____

Last Day Worked _____ Date Returned _____ Base Annual Salary _____

Hours Worked per Week _____ Workers' Comp Claim Filed _____

Employee's Occupation _____

Premium Contribution by Employer _____% Employee _____% Employee Contribution pre-tax? ☐Yes ☐No

Amount of Life Insurance Inforce _____

If injured party is a dependent spouse or child, complete the following

Dependent's Name _____ (Last) _____ (First) _____ (Middle) Social Security No. _____

Date of Birth _____ Gender _____ Relationship to Employee _____

Benefits being claimed

Amount of Life Insurance Inforce $ _____

Amount of Benefit Requested $ _____

Remaining Life Insurance $ _____

I **certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.**

_____ _____
Signature of Authorized Employer/Plan Representative Date

_____
Print Name

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Section 3 – Attending Physician's Statement

Dear Doctor:
The purpose of this report is to assist us in evaluating the patient's claim for payment of an accelerated life insurance benefit for terminal illness. In completing this report, please include sufficient details of history, physical or diagnostic findings, clinical course, therapy and response to therapy so that we are able to complete our evaluation.

THE PATIENT IS RESPONSIBLE FOR ANY EXPENSE INVOLVED IN THE COMPLETION OF THIS FORM.

PATIENT NAME _____ (Last) _____ (First) _____ (Middle)

EMPLOYEE NAME IF OTHER THAN PATIENT _____ (Last) _____ (First) _____ (Middle)

DIAGNOSIS

Date of last examination _____

Diagnosis (including any complications)

ICD-9 Code(s) _____

Please submit, with completed form, copies of all objective findings (including current test findings, x-ray reports, EKG's. Laboratory Data and clinical findings.)

HISTORY

When did the symptoms first appear or accident happen _____

Date first seen for this condition _____ Was patient referred by another physician: ☐Yes ☐No

Referring physician's name

Phone _____ Address

Email _____ _____ (Street) _____ (City) _____ (State) _____ (Zip)

NATURE AND DATES OF TREATMENT (Including medications prescribed)

SURGICAL PROCEDURES AND DATES

If confined to a hospital or other facility, provide name, address and dates of confinement:

PROGNOSIS

Have You Diagnosed this Patient as Terminally Ill: ☐Yes ☐No

Date First Diagnosed as Terminally Ill _____ Anticipated Life Expectancy _____

Physician Name _____ Specialty _____

Physician Signature _____

Address

_____ (Street) _____ (City) _____ (State) _____ (Zip)

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AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Insured Name _____ (Last) _____ (First) _____ (Middle) Date of Birth _____

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical and psychological reports; records, charts, notes – excluding psychotherapy notes -, x-rays, films or correspondence, and any medical condition(s));
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to: Blue Cross and Blue Shield of Montana
  PO Box 7070
  Downers Grove, IL 60515
- I understand the information obtained by use of this Authorization will be used by Blue Cross and Blue Shield of Montana to evaluate my claim for death benefits. BCBSMT will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As otherwise may be required by law or as I further authorize.

I further understand that refusal to sign this Authorization may result in the denial of benefits.

- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent;
  - BCBSMT has taken action in reliance on this Authorization; or
  - BCBSMT is using this Authorization in connection with a contestable claim.

If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to BCBSMT at the above address.

- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this Authorization.

_____ (Signature) _____ (Date)

_____ (Print Name)

Claimant/Legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Relationship to Claimant/Insured or personal/legal representative signing for Claimant/Insured: _____

Phone _____ Address

Email _____ _____ (Street) _____ (City) _____ (State) _____ (Zip)

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BlueCross BlueShield of Montana

Fraud Notices

Administrative Office: 701 E. 22nd Street, Lombard, Illinois 60148

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a 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.

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.

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.

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

Kentucky: 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 commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willingly 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 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.

Ohio: Any person who, with intent to defraud or knowingly 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: 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.

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 be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

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 application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

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: 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.

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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing 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.

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 NH 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.

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.

FOR APPLICATIONS ONLY:

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.