BlueCross BlueShield of Montana

Group Life Waiver of Premium Claim Form

Return to Blue Cross and Blue Shield of Montana at:
Attention: Claims Department
P.O. Box 7071
Downers Grove, IL 60515

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

INSTRUCTIONS

A Waiver of Premium claim should be filed for an eligible insured who has been continuously disabled for the length of time indicated in the policy (the waiver elimination period - usually six or nine months). However, the claim may be submitted prior to that time if it can be presumed that the employee will remain continuously disabled for the required amount of time.

Premium must continue to be paid during the waiver elimination period.

To be eligible for Waiver of Premium, the eligible employee must be under the age of sixty, or age specified in the policy, on the date their disability begins.

Please Note: Proof of disability must be received within one year of the start of the disability.

Please submit the following documentation:

1. Claim Form:

   Part 1 – Completed by the Employer/Administrator

   Part 2 - Completed by the Insured, or if deceased, by his/her Spouse, Registered Domestic Partner or Legal Representative.

   Part 3 – Completed by the Attending Physician (insured is responsible for any costs)

2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.
3. If the benefits are based on salary, submit payroll records verifying the employee's annual earnings at the time of their disability.
4. If any portion of coverage is paid for by the employee, submit proof of payroll deduction.
5. The insured person is responsible for any costs associated with completion of the Attending Physician Statement.

R040125 I Z6293_BCBSMT

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Part 1 - To be completed by Employer/Administrator

Statement of Employer

Employer/Plan Information

Group Name _____ Subsidiary Name _____

Group Number _____

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

Name and Title of Authorized Representative _____

Phone Number _____ Fax Number _____

E-Mail Address _____

Insured Person Information

Name of Claimant _____ (Last) _____ (First) _____ (Middle)

Social Security No. _____ Date of Birth _____

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

Hire Date _____ Insurance Effective Date _____ Occupation _____

Annual Salary _____ Date of Last Salary Increase _____

Amount of Insurance: Basic Life _____

Supplemental Life _____

Voluntary Life _____

Last Day Worked _____ Reason for cessation of work _____

Provide date of disability _____

Date of Last Premium Contribution: Group _____ Member _____

If the eligible insured is deceased provide proof that he/she died within one year from the date of becoming Totally Disabled, and remained Totally Disabled until the date of death.

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 may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative _____

Print Name _____ Date _____

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Part 2 - To be completed by Insured or if deceased, by his/her Spouse, Registered Domestic Partner or Legal Representative.

Name: _____ (Last) _____ (First) _____ (Middle)

Maiden Name _____ Alias Name _____

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

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

Phone _____ E-Mail _____

Are you a U.S. Citizen: ☐ Yes ☐ No (If No - IRS Form W-8 required)

Date of Accident or beginning of sickness _____

If Injury, describe how, when and where accident occurred: _____

If Illness, have you ever had same or similar illness: ☐ Yes ☐ No If yes, give dates: _____

Name of Employer _____ Last day worked _____

Occupation _____

Between what dates were you unable to perform any duties _____

Name of Treating Physician _____ Phone Number _____

Location of Hospital: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Hospital Phone Number _____

Admission Date _____ Discharge Date _____

Certification

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 may be subject to criminal and civil penalties.

Your Signature _____

Print Name _____ Date _____

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Part 3 - Attending Physician's Statement
(Insured is responsible for any costs associated with completion of the Attending Physician's Statement)

Name of Patient: _____ (Last) _____ (First) _____ (Middle)

Gender _____ Date of Birth _____

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

Date of Accident or appearance of symptoms _____

Date First Consulted _____ Date of Total Disability Diagnosis _____

Date of Permanent Disability Diagnosis _____

Has patient ever had same or similar conditions _____

Is the disability the result of an accident: ☐ Yes ☐ No

If Yes, Please list any co-morbid conditions contributing to the disability:

_____

Diagnosis/ICD 9/10 _____

Is patient still under your care: ☐ Yes ☐ No Last Date of Treatment _____

Patient can return to work on _____ Full-Time ☐ Yes ☐ No Part-Time ☐ Yes ☐ No

# of hrs per day _____ Week _____

Patient disabled (unable to work) Own Occupation _____ Any Occupation _____

Patient disabled (unable to work) Own Occupation _____ Any Occupation _____

Symptoms _____

Treatment _____

Medications _____

Limitations/Restrictions _____

Specialist Referral to _____

Physician Name _____ Specialty _____

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

Telephone _____ Fax _____ EIN/SSN _____

Signature _____

Print Name _____ Date _____

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AGREEMENTS AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize my employer to disclose all information necessary to process my claim to Blue Cross and Blue Shield of Montana.

I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to BCBSMT's claim department or its authorized representative(s) information about my medical history or treatment and/or furnish copies of my hospital and/or medical records including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse and mental illness. I further authorize BCBSMT to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.

This authorization shall expire on the date that I received notice of BCBSMT's final decision on my claim. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by BCBSMT prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy rule;
- I should retain a copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of my authorization from BCBSMT.

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, BCBSMT has the right to deny my claim.

Signature _____

Print Name _____ Date _____

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:

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

Phone No. _____

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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.