Health Screening Benefit Claim Form

This claim form can be used to request reimbursement for your Health Screening Benefits under your Critical Illness or Supplemental Health plan. You can either have your physician complete and sign the information below or attach documentation from the provider indicating the date of service, and the service provided (description or CPT code).

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on pages 3-4)

Service Information:

Date services were rendered____/_____/_____

Please check all services provided below: The claim must be completed and signed by your physician or include an itemized billing from your provider that includes the date of service and service(s) provided (CPT codes).

- ☐ Bone Marrow Testing
- ☐ Chest X-ray
- ☐ Flexible Sigmoidscopy Pap Smear
- ☐ Biopsy for Skin Cancer
- ☐ Lipid Panel
- ☐ Serum Protein Electrophoresis
- ☐ CEA (Colon Cancer)
- ☐ Stress EKG
- ☐ PSA (Prostate Cancer)
- ☐ Stress Test (bike or treadmill) CA-125 (Ovarian Cancer)
- ☐ Colonoscopy
- ☐ Electrocardiogram (EKG)
- ☐ Mammography (including ultrasound
- ☐ Oral Cancer Screening using ViziLite, OraTest or dental code D0431

Hospital Indemnity Only

- ☐ 3 Blood pressure readings in 14 days with health care practitioner attestation
- ☐ Blood Glucose Test A1C1 Test (Diabetes)
- ☐ Water Displacement Test(Obesity)
- ☐ Skin Caliper Test (Obesity)

The below Statements are true to the best of my knowledge and belief.

_____ _____/_____/_____

Signature of Subscriber Date

Is the claim for the: Subscriber ☐ Dependent ☐

Subscriber's Name_____PolicyNo._____
Social Security No._____Mailling Address_____
City_____State_____ZIPCode_____Date of Birth_____/_____/_____
Daytime Phone Number (____)_____
Claimant Name_____Date of Birth_____/_____/_____

Provider Information:

Printed Name of Physician _____Phone No. (____)_____

Street Address_____Specialty_____

City_____State_____ZIP Code_____

Signature of Physician _____ Date_____/_____/_____

ManhattanLife℠ Since 1850

Mail to the following address:

ManhattanLife
Claims
P.O. Box 926169
Houston, TX 77092

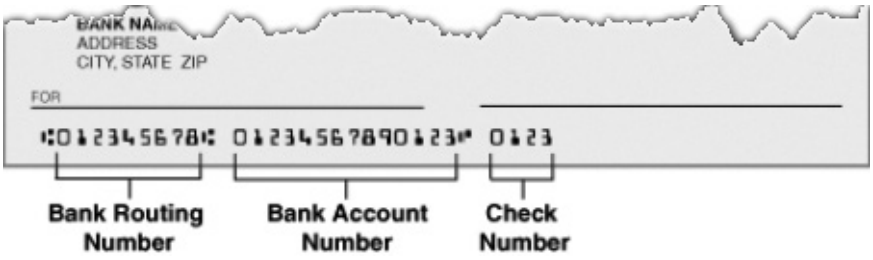
Customer Service: 1-855-448-6982
Fax to: 1-502-405-7107
Email to:
vbclaimssubmissions@manhattanlife.com

Direct Deposit Authorization

Check Action			Effective Date			Acct. Type		Ownership of Account		
☐	☐	☐	☐☐ – ☐☐ – ☐☐☐☐			☐	☐	☐	☐	☐
New	Change	Cancel	Month	Day	Year	Checking	Savings	Self	Joint	Other

Bank Name _____

Bank Routing Number _____ Bank Account Number _____



Subscriber's Name_____

Policy No._____

I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize ManhattanLife to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____ ____/____/____

Signature Date

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

_____ ____/____/____

Signature Date

Terms And Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program please read the following terms and conditions for participation carefully before making your decision. Not all polices may qualify.

1. Once the Form is received by ManhattanLife, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify ManhattanLife of any changes to your account immediately.** Complete this form indicating the action is a CHANGE, and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a cancel, and return it to the address on the front. Your participation will be cancelled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to ManhattanLife or cannot be made to your account, ManhattanLife will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be cancelled by your financial institution or ManhattanLife. **Your participation will be cancelled automatically if you terminate participation in the above Account(s).**

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State Specific Fraud Warning Statements

ManhattanLife:

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:

Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

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.

Arkansas, Louisiana, 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.

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.

California:

For your protection California law requires the following statement 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:

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.

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, 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.

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State Specific Fraud Warning Statements

Kansas:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maryland:

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:

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 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.

Virginia:

Any person who, with the 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 may have violated the state law.