Claim Form and Instructions

To ensure smooth processing of your claim, please read the instructions carefully and complete all required information.

When you chose Colonial, you chose a financially strong company with more than 50 years of experience and an ongoing commitment to quality customer service. You can count on us to deliver what we promise.

Things You Should Know!

- By calling 1-800-325-4368, you can obtain general information on your claim twenty-four hours a day, seven days a week. Please allow us 48 hours to update our system on Faxed claims.

- You can FAX us your claim at 1-800-880-9325. Faxing your claims means your claim will be received three to five days faster.

- For Pregnancy and Wellness claims, ONLY complete the Express Filing forms on pages 7 and 8.

- Wellness Claims can even be called in to 1-800-325-4368 rather than filing by mail. All we need is your wellness test, date of treatment, treating physician, and physician's phone number. We will call to verify the test and mail your benefit payment, often the same day.
Mail claim form and enclosures directly to: OR Fax claim form and enclosures directly to:

Colonial Life & Accident Insurance Company
Post Office Box 100195
Columbia, South Carolina 29202-3195

1-800-880-9325 (limit 20 pages)

Refer to your Service Guide for Colonial Policyholders for additional information.

Want Fast Claims Service? Follow these TIPS Closely!

■ Please do not use highlighter on the claim form if faxing. (It is not necessary to mail originals if you use fax mail box.)

■ Most claims take longer when information is missing. Follow the chart below and complete all information.

■ Page 6 of the claim form is for you and your doctor to complete. Just attaching a doctor’s bill may not be enough to have your claim paid. We must have a diagnosis from your doctor. Missing Patient Social Security Number can delay processing your claim.

■ Please complete Section F and sign your authorization. Without your signature, we will not be able to process your claim.

■ If you are filing for disability benefits, please notify us of any changes in your condition and/or treatment. We will advise you if additional claim form(s) are needed. Please notify us when you return to work.

■ Your policy may include a first year pre-existing condition exclusion. If so, we may need additional medical information to process your claim. To speed the process, please provide detailed medical information in Section D and have your doctor complete Question 4 on page 5.

■ Attach all doctor and hospital bills or FAX them with your claim form.

■ If you sign Line 13 on page 6, Colonial will pay all benefits to the doctor or hospital listed. Make sure this is what you want us to do!

Please refer to this chart for the sections you need to complete on your claim form. Your medical provider is to complete pages 5 and 6.

<table>
<thead>
<tr>
<th>Policy Type</th>
<th>Section A</th>
<th>Section B</th>
<th>Section C</th>
<th>Section D</th>
<th>Section E</th>
<th>Section F</th>
<th>Express Filing</th>
<th>Attachments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Detailed itemized bills</td>
</tr>
<tr>
<td>Sickness</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>Detailed itemized bills</td>
</tr>
<tr>
<td>Hospital Income</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Detailed itemized bills</td>
</tr>
<tr>
<td>Cancer</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>Pathology Report and itemized bills</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>Detailed itemized bills</td>
</tr>
<tr>
<td>Wellness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>Detailed itemized bills</td>
</tr>
<tr>
<td>Pregnancy Claim</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

***NOTE: Section E should be only completed if you are filing for DISABILITY benefits.
*A diagnosis is required from your doctor or medical facility for all claims.
**SECTION A**

<table>
<thead>
<tr>
<th>Policyholder Information</th>
<th>Patient Information (Check one)</th>
<th>Social Security Number</th>
<th>IMPORTANT</th>
<th>Birthdate (mm/dd/yyyy)</th>
<th>Social Security Number</th>
<th>IMPORTANT</th>
<th>Birthdate (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name (First, Middle, Last)</td>
<td></td>
<td>Male</td>
<td></td>
<td>Female</td>
<td>Name (First, Middle, Last)</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Address (Street)</td>
<td>Check here if NEW address</td>
<td>Apt #</td>
<td></td>
<td></td>
<td>Address (Street)</td>
<td>Check here if NEW address</td>
<td>Apt #</td>
</tr>
<tr>
<td>City</td>
<td></td>
<td>State</td>
<td>Zip Code</td>
<td></td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Numbers (if known)</th>
<th>Home phone number</th>
<th>Work phone number</th>
<th>ext.</th>
<th></th>
<th>Home phone number</th>
<th>Work phone number</th>
<th>ext.</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
<td></td>
<td>( )</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>This Claim is for:</th>
<th>Accident</th>
<th>Wellness</th>
<th>Intensive Care</th>
<th>Hospital Income</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sickness</td>
<td>Cancer</td>
<td>(If claim is being filed for cancer, enclose pathology report.)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION B** — IF ACCIDENTAL INJURY

Date (mm/dd/yyyy) you were injured: Time of accident: Where did it happen?

<table>
<thead>
<tr>
<th>Time</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How did it happen?

Did your injuries occur while you were working for pay or profit?

<table>
<thead>
<tr>
<th>Yes (on-job)</th>
<th>No (off-job)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Have you received treatment, medication or advice from a doctor in the past for this or a similar condition?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, date (mm/dd/yyyy) last seen:

Dates (mm/dd/yyyy) unable to work:

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If sports injury, what type (i.e., high school, junior high, etc.):

**SECTION C** — IF SICKNESS/ILLNESS/CANCER/INTENSIVE CARE/HOSPITAL INCOME/OTHER

What type of illness are you claiming?

When were you first treated for this illness? (Date mm/dd/yyyy)

<table>
<thead>
<tr>
<th>Have you ever had the same or similar condition in the past?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES NO</td>
</tr>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

Were you unable to work due to this illness in the last six months to a year?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

Dates (mm/dd/yyyy) unable to work:

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CLAIM FORM CONTINUED — REVERSE SIDE
### SECTION D  YOUR MEDICAL INFORMATION (Please attach a separate sheet if additional space is needed)

<table>
<thead>
<tr>
<th>Primary Doctor</th>
<th>Treating Doctor</th>
<th>Referring Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Address (Street)</td>
<td>Address (Street)</td>
<td>Address (Street)</td>
</tr>
<tr>
<td>City, State, Zip Code</td>
<td>City, State, Zip Code</td>
<td>City, State, Zip Code</td>
</tr>
<tr>
<td>Telephone Number ( )</td>
<td>Telephone Number ( )</td>
<td>Telephone Number ( )</td>
</tr>
</tbody>
</table>

### HOSPITAL INFORMATION (If ever hospitalized or seen at the hospital)

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Hospital Name</th>
<th>Hospital Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>Telephone Number ( )</td>
<td>Telephone Number ( )</td>
<td>Telephone Number ( )</td>
</tr>
<tr>
<td>Date Seen/Admitted</td>
<td>Date Seen/Admitted</td>
<td>Date Seen/Admitted</td>
</tr>
<tr>
<td>Date Discharged</td>
<td>Date Discharged</td>
<td>Date Discharged</td>
</tr>
</tbody>
</table>

### SECTION E  EMPLOYER SECTION (to be completed by an authorized person at your place of employment)

<table>
<thead>
<tr>
<th>Employee Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s job title duties include:</td>
</tr>
<tr>
<td>Lifting</td>
</tr>
<tr>
<td>Stooling/bending</td>
</tr>
<tr>
<td>Reaching/pulling</td>
</tr>
<tr>
<td>Management duties</td>
</tr>
<tr>
<td>Sitting (Number of hours each day)</td>
</tr>
<tr>
<td>Standing/Walking (hours each day)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number ( )</td>
</tr>
<tr>
<td>Dates (mm/dd/yyyy) employee unable to work</td>
</tr>
<tr>
<td>FROM: ☐ AM ☐ PM TO: ☐ AM ☐ PM</td>
</tr>
<tr>
<td>Date (mm/dd/yyyy) employee returned to his/her main or principal duties:</td>
</tr>
<tr>
<td>Returned part-time</td>
</tr>
<tr>
<td>Is Workers’ Compensation being filed for?</td>
</tr>
<tr>
<td>Did the accident occur while working for wage or profit?</td>
</tr>
<tr>
<td>Signed</td>
</tr>
</tbody>
</table>

### SECTION F

For your protection, California and other states’ law requires the following to appear on this form: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this claim form may also constitute a crime under federal laws. We will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate. (Florida - Felony of the third degree)

**AUTHORIZATION**

I have checked the above answers and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I hereby authorize any medical practitioner or facility, psychologist, social worker, hospital, clinic, including the Veterans Administration, insurance or reinsuring company, consumer reporting agency, employer, Social Security Administration, Medical Information Bureau, Inc., insurance support organization, or other organization or person having medical and non-medical information or knowledge of me or my minor children, to give to Colonial Life & Accident Insurance Company, hereinafter called the Company, its authorized representative any and all information. This Authorization shall include information concerning alcohol or drug abuse, mental health, AIDS or AIDS-related conditions. I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance or eligibility for benefits under an existing policy. I authorize the Company to release any such information to reinsuring companies, the Medical Information Bureau, Inc., persons or organization performing business, legal, medical or insurance services related to me or my minor children insurance or claim under that insurance, or any other public or private entity as may be lawfully required. I understand that I may receive a copy of this Authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for the duration of my claim not to exceed two and one-half years from the date shown below.

**DATE (mm/dd/yyyy) PATIENT SIGNATURE**

**POLICYHOLDER SIGNATURE**

**SOCIAL SECURITY NUMBER**
To be answered by your medical provider:

1. If surgery has been performed, please attach a copy of the operative report.

2. If due to Cancer, please enclose a Pathology Report.

3. If due to an accident, please provide complete information, date and description.

4. Has this patient been treated for this same or similar condition in the past, prior to this occurrence? If so, please list the diagnosis and the dates of treatment.

Please complete the following questions regarding your patient's status:

1. Is your patient able to work? ☐ Yes ☐ No If No, what medical restrictions or limitations have been placed on this patient preventing his/her return to work?

2. If multiple conditions exist, what is the primary disabling condition?

3. Nature of treatment/treatment plan (including surgery and medication prescribed, if any).

Medical Provider's Signature ___________________________ Date (mm/dd/yyyy)
### HEALTH INSURANCE CLAIM FORM

1. **MEDICARE**  
   - Medicare #  
   - [ ] Medicare #  
   - [ ] (Social Security Number)  
   - [ ] (Sponsor’s SSN)  
   - [ ] (If not Medicare)  

2. **PATIENT’S NAME (Last Name, First Name, Middle Initial)**  

3. **PATIENT’S DATE OF BIRTH**  
   - Month  
   - Day  
   - Year  

4. **INSURED’S NAME (Last Name, First Name, Middle Initial)**  

5. **PATIENT’S ADDRESS (No., Street)**  

6. **PATIENT’S POSTAL ADDRESS (No., Street)**  

7. **INSURED’S ADDRESS (No., Street)**  

8. **PATIENT STATUS**  
   - Single  
   - Married  
   - Other  

9. **OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)**  

10. **IS PATIENT’S CONDITION RELATED TO:**  
    - [ ] Employment? (Current or Previous)  
    - [ ] Yes  
    - [ ] No  
    - [ ] Auto Accident?  
    - [ ] Yes  
    - [ ] No  
    - [ ] Other Accident?  
    - [ ] Yes  
    - [ ] No  

11. **INSURED’S POLICY GROUP OR FECA NUMBER**  

12. **READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**  
    - [ ] Yes  
    - [ ] No  

13. **IS THERE ANOTHER HEALTH BENEFIT PLAN?**  
    - [ ] Yes  
    - [ ] No  

14. **DATE OF CURRENT ILLNESS:**  
   - Month  
   - Day  
   - Year  

15. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS:**  
   - Give First Date  
   - Month  
   - Day  
   - Year  

16. **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:**  
   - From  
   - Month  
   - Day  
   - Year  
   - To  
   - Month  
   - Day  
   - Year  

17. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**  

18. **HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS:**  
   - From  
   - Month  
   - Day  
   - Year  
   - To  
   - Month  
   - Day  
   - Year  

19. **RESERVED FOR LOCAL USE**  

20. **OUTSIDE LAB?**  
    - [ ] Yes  
    - [ ] No  

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:**  
   - [ ] Yes  
   - [ ] No  

22. **MEDICAID RESUBMISSION CODE**  
    - [ ] Original Ref. No.  

23. **PRIOR AUTHORIZATION NUMBER**  

24. **A**  
   - From  
   - Month  
   - Day  
   - Year  
   - To  
   - Month  
   - Day  
   - Year  
   - Place of Service  
   - Type of Service  
   - Procedures, Services, or Supplies  
   - (Explain Unusual Circumstances)  
   - Diagnosis Code  
   - $ Charges  
   - Days or Unes  
   - EPSDT Family Plan  
   - EMG  
   - COB  
   - Reserved For Local Use  

25. **FEDERAL TAX I.D. NUMBER**  
   - SSN  
   - EIN  

26. **PATIENT’S ACCOUNT NO.**  

27. **ACCEPT ASSIGNMENT**  
   - [ ] Yes  
   - [ ] No  

28. **TOTAL CHARGE**  
   - [ ] $  

29. **AMOUNT PAID**  
   - [ ] $  

30. **BALANCE DUE**  
   - [ ] $  

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**  
   - (Certify that the statements on the reverse apply to this bill and are made a part thereof.)  

32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)**  

33. **PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, ZIP CODE & PHONE #.**  

---

** PLEASE PRINT OR TYPE

(ABOUT BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
**Express Filing for Pregnancy Claim**

This is for normal recovery period only. If you are totally disabled prior to delivery or beyond 6 weeks for vaginal delivery and 8 weeks for C-section delivery, please complete a claim form for disability.

<table>
<thead>
<tr>
<th>Policy Number (If known)</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Policyholder Name (First, Middle, Last)</th>
<th>Social Security Number</th>
<th>Birthdate (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Address (Street)</th>
<th>(City)</th>
<th>(State)</th>
<th>(Zip Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Patient's name: Patient's Social Security #

4. Delivery Date (mm/dd/yyyy):
   - [ ] Vaginal
   - [ ] C-section

   First Date (mm/dd/yyyy) of Treatment Including Any Phone Consultations

5. Doctor's Signature

   Date (mm/dd/yyyy)

   Tax Identification Number

6. Doctor's Name & Address (Please Print)

   Phone Number

7. Referring Physician's Name & Address

8. Hospital Name

   Dates of Hospital Confinement

9. Hospital Address

   Phone Number

---

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I have checked the above answers and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I hereby authorize any medical practitioner or facility, psychologist, social worker, hospital, clinic, including the Veterans Administration, insurance or reinsuring company, consumer reporting agency, employer, the Social Security Administration, Medical Information Bureau, Inc., insurance support organization, or other organization or person having medical and non-medical information or knowledge of me or my minor children, to give to Colonial Life & Accident Insurance Company, hereinafter called the Company, or its authorized representative any and all information. This Authorization shall include information concerning alcohol or drug abuse, mental health, AIDS or AIDS-related conditions. I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance or eligibility for benefits under an existing policy. I authorize the Company to release any such information to reinsuring companies, the Medical Information Bureau, Inc., persons or organization performing business, legal, medical or insurance services related to me or my minor children insurance or claim under that insurance, or any other public or private entity as may be lawfully required. I understand that I may receive a copy of this Authorization upon request, agree that a photostatic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for the duration of my claim not to exceed two and one-half years from the date shown below.

---

DATE (mm/dd/yyyy)  POLICYHOLDER SIGNATURE  PATIENT SIGNATURE

49507-3
FAX 1-800-880-9325
P. O. Box 100195
Columbia, SC 29202-3195

Please complete the section that applies to you.
Please Allow Two Weeks after Mailing your Claim for us to Process.

Express Filing for Cancer Screening Wellness Benefit
(Please Refer to Your Cancer Policy for the Specific Tests that are Covered.)

For Express Service You Must Send the Following Information from your Doctor.
■ The type of cancer wellness screening that was performed, date of service, and copy of bill.
■ If you are treated at a non-cost incurred facility, please furnish verification from the facility of the date and type of test performed.

1. Patient Name (First, Middle, Last) ☐ Spouse ☐ Male ☐ Female Patient Social Security Number
Birthdate (mm/dd/yyyy) Phone Number Policy Number (If known)

2. Type of Test Performed Date Test Performed (mm/dd/yyyy)

3. Doctor's Name & Address Doctor's Phone #

4. Policyholder Name (First, Middle, Last) ☐ Male ☐ Female Social Security Number Birthdate (mm/dd/yyyy)
City (City) State (State) Zip Code (Zip Code)

For your protection, California and other states' law requires the following to appear on this form: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this claim form may also constitute a crime under federal laws. We will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate. (Florida - Felony of the third degree)

I have checked the above answers and they are correct. I certify under penalty of perjury that my correct social security number is shown on this form. I hereby authorize any medical practitioner or facility, psychologist, social worker, hospital, clinic, including the Veterans Administration, insurance or reinsurance company, consumer reporting agency, employer, the Social Security Administration, Medical Information Bureau, Inc., insurance support organization, or other organization or person having medical and non-medical information or knowledge of me or my minor children, to give to Colonial Life & Accident Insurance Company, herewith called the Company, or its authorized representative any and all information. This Authorization shall include information concerning alcohol or drug abuse, mental health, AIDS or AIDS-related conditions. I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for insurance or eligibility for benefits under an existing policy. I authorize the Company to release any such information to reinsuring companies, the Medical Information Bureau, Inc., persons or organization performing business, legal, medical or insurance services related to me or my minor children insurance or claim under that insurance, or any other public or private entity as may be lawfully required. I understand that I may receive a copy of this Authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for the duration of my claim not to exceed two and one-half years from the date shown below.

DATE (mm/dd/yyyy) POLICYHOLDER SIGNATURE PATIENT SIGNATURE

Filing for Transportation (For Cancer Policies Only)
*** FOR INTERNAL CANCER ONLY – Please Refer to your Cancer Policy to see if the Transportation Benefit is applicable ***

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Policy Number (If known)</th>
<th>Patient Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date (mm/dd/yyyy) Mileage From (City) To (City)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please attach verification of treatment dates from your doctor's office.