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Phone (800) 433-3036 *
Fax (866) 849-2970
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WELLNESS AND HEALTH SCREENING CLAIM FORM

Failure to complete all sections may result in delayed processing of this claim.
Review your policy for specific benefits covered under your plan.

AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance company, consumer report agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information for me, to give to Continental American Insurance Company or its legal representative, any and all such information. This information is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug or alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. I UNDERSTAND the information obtained by use of the Authorization will be used by Continental American Insurance Company to determine eligibility for benefits under an existing certificate. Any information obtained will not be released by Continental America Insurance Company to any person or organization EXCEPT to re-insuring companies, or other person or organization performing business or legal services in connection with any claim, or as may otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that this authorization shall be valid for the duration of my claim.

Policyholder's Signature: **Date:** **Claimant's Signature:** **Date:**

POLICYHOLDER/PATIENT INFORMATION

EMPLOYER'S NAME		POLICYHOLDER'S EMAIL ADDRESS		
MAJOR MEDICAL INSURANCE PROVIDER		MAJOR MEDICAL INSURANCE ID#		
POLICYHOLDER'S NAME	POLICY NO	SSN/ EMPLOYEE ID	DATE OF BIRTH	GENDER
POLICYHOLDER'S ADDRESS CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE	CITY	STATE	ZIP CODE	POLICYHOLDER'S PHONE NUMBER
PATIENT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	PATIENT'S DATE OF BIRTH	PATIENT'S GENDER	

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you).

HEALTH SCREENING INFORMATION

DATE HEALTH SCREENING TEST WAS PERFORMED:

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:

Annual Physical	DNA Stool Analysis	Non-Diagnostic Vascular Screening
Biometric Screening	Eye Examinations	Pap Smears
Blood Screening	Fasting Blood Glucose	PSA Test
Blood Test for Triglycerides	Flexible Sigmoidoscopy	Serum Cholesterol Test
Bone Marrow Testing	Hemoccult Stool Analysis	Serum Protein
Breast Ultrasound	HIV (Human Immunodefiency)	Skin Cancer Screening
CA 125	HPV (Human Papillomavirus)	Spinal CT Screening
CA 15-3	HSN Strains	Stress Test on Bicycle or Treadmill
CEA	Human Coronavirus Testing	Thermography
Chest X-Ray	Immunizations	Ultrasounds
Colonoscopy	Mammograms	Urinalysis

PHYSICIAN INFORMATION

NAME	TELEPHONE NUMBER		
ADDRESS	CITY	STATE	ZIP CODE