

## INSURANCE BENEFITS PROVIDED BY RESERVE NATIONAL INSURANCE COMPANY

A Kemper Life & Health Company

P.O. Box 9988

Austin, TX 78766-9988

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### WELLNESS BENEFIT CLAIM FORM UNDER CANCER/SPECIFIED DISEASE COVERAGE

Instructions to File a Claim:

- Please complete Insured/Claimant Statement and mail or fax the completed form to the address or fax number indicated above.
- In order to document the contents of this form, the Insured and Claimant (if an adult) must sign and date the completed claim form.
- Please attach a copy of itemized bill indicating patient name, date of service, name of provider, type of service, and diagnosis code.

#### Insured/Claimant Statement

Insured's Name (Last, First, Middle)	Policy/Certificate #	Social Security No.	Date of Birth	Sex																										
Address (Street, City, State, Zip)		Phone Number (With Area Code)																												
Claimant's Name	Date of Birth	Relationship to Insured																												
<p>Please circle the appropriate wellness screening and provide itemized bill.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Abdominal aortic aneurysm ultrasound</td> <td style="width: 50%;">Fasting blood glucose test</td> </tr> <tr> <td>Blood test for triglycerides</td> <td>Flexible sigmoidoscopy</td> </tr> <tr> <td>Bone marrow testing</td> <td>Hemoccult stool analysis</td> </tr> <tr> <td>Breast ultrasound</td> <td>Mammography</td> </tr> <tr> <td>CA 15-3 (blood test for breast cancer)</td> <td>Pap Smear</td> </tr> <tr> <td>CA 125 (blood test for ovarian cancer)</td> <td>PSA (blood test for prostate cancer)</td> </tr> <tr> <td>Carotid ultrasound</td> <td>Serum cholesterol HDL/LDL</td> </tr> <tr> <td>CEA (blood test for colon cancer)</td> <td>Serum protein electrophoresis (blood test for myeloma)</td> </tr> <tr> <td>Chest x-ray</td> <td>Stress Test</td> </tr> <tr> <td>Colonoscopy</td> <td>Thermography</td> </tr> <tr> <td>CT Angiography</td> <td></td> </tr> <tr> <td>EKG</td> <td></td> </tr> <tr> <td>Double contrast barium enema</td> <td></td> </tr> </table>					Abdominal aortic aneurysm ultrasound	Fasting blood glucose test	Blood test for triglycerides	Flexible sigmoidoscopy	Bone marrow testing	Hemoccult stool analysis	Breast ultrasound	Mammography	CA 15-3 (blood test for breast cancer)	Pap Smear	CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)	Carotid ultrasound	Serum cholesterol HDL/LDL	CEA (blood test for colon cancer)	Serum protein electrophoresis (blood test for myeloma)	Chest x-ray	Stress Test	Colonoscopy	Thermography	CT Angiography		EKG		Double contrast barium enema	
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#### AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE \_\_\_\_\_ INSURED'S SIGNATURE: \_\_\_\_\_

DATE \_\_\_\_\_ CLAIMANT'S SIGNATURE: \_\_\_\_\_