

## INSURANCE BENEFITS PROVIDED BY RESERVE NATIONAL INSURANCE COMPANY

A Kemper Life & Health Company  
P.O. Box 9988, Austin, TX 78766-9988  
Telephone: 844-613-6245 Fax: 844-473-8084  
Email: service@kemperbenefits.com

### CRITICAL ILLNESS CLAIM FORM

**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 have the treating physician complete the Attending Physician Statement. Your physician may mail or fax the completed form to the address or fax number indicated above.
- Please have your physician provide the applicable documents in order to avoid a delay in processing.

#### Insured/Claimant Statement

Insured's Name (Last, First, Middle)		Policy #	Social Security No.	Date of Birth	Sex
Address (Street, City, State, Zip)			Phone Number (With Area Code)		
Claimant's Name (Person who is sick)		Date of Birth	Relationship to Insured		
Nature of illness		When have you had this same or similar condition?			
When did symptoms first appear?	Date first diagnosed?	Date first treated?			
Name and address of physician (list all physicians consulted)					
Have you been confined to a hospital for this condition? Yes No		Please provide name and address of hospital:			
Admission date:	Discharge date:				
Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? Yes or No					
If yes, when?					

#### 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, 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: \_\_\_\_\_

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### Critical Illness Attending Physician's Statement

*(Must be completed by physician. Please complete all applicable questions and provide copies of the supporting reports, medical records, and/or tests.)*

Patient's Full name	Policy or Certificate Number	Date of Birth
Diagnosis? (Please use ICD 9 codes)	When did symptoms first appear?	When did the patient first consult you for this condition?
<b>CANCER/CANCER IN SITU</b>		
Please circle if cancer was <u>pathology diagnosed</u> or <u>clinically diagnosed</u> .		
Date of Diagnosis: _____		
Has the patient ever had the same or similar condition? YES NO		
(If Cancer/Cancer In Situ was pathologically diagnosed, please attach a copy of the pathology report. If the Cancer/Cancer In Situ was clinically diagnosed, please provide the reasons that pathological diagnosis was not obtained and attach medical documentation that supports the diagnosis of Cancer.)		
<b>COMA</b>		
Has the patient been in a continuous state of profound unconsciousness for at least 14 days? YES NO		
Has the patient required intubation for respiratory assistance? YES NO		
(Please attach copies of clinical diagnosis)		
<b>CORONARY ARTERY BYPASS SURGERY/ANGIOPLASTY</b>		
Type of Surgery: _____ Date of Surgery: _____		
(Please provide surgical report)		
<b>END-STAGE RENAL FAILURE</b>		
Has there been chronic, irreversible failure of the function of both kidneys? YES NO		
Has the patient undergone peritoneal dialysis on a weekly basis? YES NO		
(Please attach copies of medical records documenting end-stage renal failure and frequency of dialysis.)		
<b>HEART ATTACK</b>		
Has the patient shown an elevation of cardiac enzymes? YES NO		
Were there associated new electrocardiographic (EKG) changes consistent with injury? YES NO		
Were there confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms? YES NO		
(Please attach copies of EKG, lab results, and other diagnostic test results.)		
<b>MAJOR HUMAN ORGAN TRANSPLANT SURGERY</b>		
Has the patient been the recipient of a human-to-human transplant of a heart, lung, liver, heart-lung, kidney, or pancreas? YES NO		
Date of surgery: _____ (Please attach copy of operative report.)		
<b>MAJOR THIRD DEGREE BURNS</b>		
Does the tissue damage in which there is destruction of the entire epidermis and underlying dermis cover more than 10% of total body surface area? YES NO		
(Please provide clinical documentation indicating total body surface area.)		
<b>OCCUPATIONAL HIV</b>		
Has the patient undergone a blood test within 5 days of the accident that indicates the absence of HIV or antibodies of the HIV Virus? YES NO		
Has the patient undergone further blood tests within 12 months that indicates the presence of HIV or antibodies of the HIV Virus? YES NO		
(Please provide clinical diagnosis.)		
<b>PARALYSIS/ALZHEIMER'S DISEASE/PARKINSON'S DISEASE/MUSCULAR DYSTROPHY/BENIGN BRAIN TUMOR/BONE MARROW TRANSPLANT/LOSS OF SIGHT, SPEECH OR HEARING</b>		
Date of Diagnosis: _____		
(Please provide clinical documentation)		
<b>STROKE</b>		
Has a cerebrovascular event occurred resulting in permanent, neurological impairment and resulted in paralysis or other measurable objective neurological defect persisting for at least 30 days? YES NO		
Have there been documented neurological deficits? YES NO		
Have there been confirmatory neuron-imaging studies? YES NO		
(Please attach copies of all documented neurological deficits and confirmatory neuron-imaging studies.)		
Physician's Name (please print):	Degree:	Phone No.
Signature:	Fax No.	