surebridge®
Underwritten by The Chesapeake Life Insurance Company®

P.O. Box 31384
Salt Lake City, UT 84131-0384

Supplemental Insurance Claim Form Packet

The Chesapeake Life Insurance Company strives to provide easy and accurate claim filing information to our Insured Customers. This packet contains all the required forms for submission of a claim for supplemental insurance benefits. Follow this Claim Form Guide below and the instructions included on the Claim Forms to submit your complete claim.

Claim Form Guide

The following is a guide for the forms within this packet necessary to file a claim based on the type of loss incurred*.
Please complete all required fields on the necessary forms and attach additional documentation that is identified on each form when you submit your claim.
Please Note: Missing or incomplete information could result in a delay in processing or closure of your claim.

What forms and information do I need to submit for my claim type?

☐ **Illness/Sickness Claim**
(Including cancer or other critical illness)
- *Claims Authorization for the Release of Information, page 2*
- *Illness and Sickness Claim Form, page 3*
- *Physician's Statement (for proof of diagnosis if not indicated on provider billing), page 7*

☐ **Accidental Injury Claim**
- *Claims Authorization for the Release of Information, page 2*
- *Accidental Injury Claim Form, page 4*
- *Physician's Statement (for proof of diagnosis if not indicated on provider billing), page 7*

☐ **Disability Income Claim**
- *Claims Authorization for the Release of Information, page 2*
- *Patient Disability Income Claim Form, page 5*
- *Employer Total Disability Statement, page 6*
- *Physician's Statement, page 7*
- *Proof of income for past 12 months*

☐ **Wellness Claim**
- *Claims Authorization for the Release of Information, page 2*
- *Wellness Claim Form, page 8*

Where do I mail my form(s) and information?

The Chesapeake Life Insurance Company
P.O. Box 31384
Salt Lake City, UT 84131-0384
Or Fax to 1-888-839-4227

**Additional information may be requested based on the type of loss incurred to determine eligibility for benefits according to the terms of your policy.*

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Claims Authorization for the Release of Information

(Please Retain a Copy for your Records)

Purpose: This form is requested so that The Chesapeake Life Insurance Company may collect information in connection with a claim for benefits on:

Insured or Dependent Child Name:	
Policy Number:	

Section A: Medical Information Request

By my signature below, I authorize the release of medical information by all health care providers, including physicians, pharmacies, clinics, hospitals, pharmacy benefit manager and any other institution, who has provided health care services, or has record of such services provided, to me or my dependent child listed above to The Chesapeake Life Insurance Company in order to determine eligibility of a claim.*

Medical information includes but is not limited to *Physician's Office Notes, Physical Therapy Notes, Complete Hospital Records* for emergency room services, inpatient services and discharge, and all *Diagnostic Testing Results* (including radiology, pathology and laboratory results). This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to mental health, substance abuse, psychotherapy, reproductive health, and communicable diseases, unless otherwise restricted by state law.

Section B: Other Information Request

By my signature below, I authorize the release of any applicable police or incident reports necessary to determine eligibility of a claim.

Section C: Expiration and Revocation

This authorization is voluntary. I understand that this authorization is valid for one year from the date shown below. I may not be denied treatment, payment for health services, or enrollment or eligibility for health care benefits if I do not sign this form. I understand that I may revoke this authorization at any time by giving written notice of my revocation. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you receive my written notice of revocation, but may result in a claim being denied or may otherwise adversely affect a pending insurance action. I understand that I have the right to receive a copy of this authorization.

Section D: Re-Disclosure

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance.

Insured Name (printed):_____ Authorized Rep Name: _____

Insured Signature: _____ Authorized Rep Signature: _____

Date: _____

If this authorization is signed by an individual's authorized representative, please attach a copy of the legal document appointing you to act in this capacity.

**An additional Physician or Facility specific authorization may be required before releasing records.*

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ILLNESS / SICKNESS CLAIM FORM

Insured Information			
Primary Insured Name		Policy Number	
Contact Information	Mailing Address (Street):		
	City:	State:	Zip Code:
	Day Phone:	Email:	
	☐ *Check box if this information is to become a permanent change to your contact information*		
Patient Information			
Patient Name		Patient Date of Birth	____/ ____ / _____
Other Insurance	Does the patient have any other Medical or Supplemental insurance; including, but not limited to Worker's Compensation, Medicare, Medicaid or any other State program?		☐ Yes ☐ No
	If yes, carrier type: ☐ Medical ☐ Supplemental ☐ Worker's Compensation ☐ Medicare ☐ Medicaid ☐ Other State Program		
	Carrier Name:		
	Carrier Phone Number:		
Illness/Sickness Information			
Nature of Illness/Sickness			
Illness/Sickness Date began	____/ ____ / _____	Diagnosis*	
*Please provide proof of diagnosis (from medical billing or signed Physician's Statement, page 7)			
Date(s) of Treatment Or Services			
Was there Hospital Confinement?	If yes, please submit itemized hospital bill including room and board charges		
Was there Ambulance Transport?	If yes, please submit the ambulance bill		
Attending/Treating Physician/Facility for this condition	Primary Physician/Facility:		
	Mailing Address:		
	City:	State:	Zip Code:
	Phone Number:	Fax Number:	
Please submit any additional medical information or other documentation from your health provider relative to this diagnosis for the review of benefits.			

Other Physicians Seen In Past 5 Years			
Other Physicians seen in the last 5 years?*	Name	Reason for Treatment	Phone Number

Please note: Failure to complete all form sections may result in a delay in processing this claim.

Claim Form Fraud Warning

I agree that all statements and answers in this Form are true to the best of my knowledge and belief. I also understand 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. (See State Specific Claim Form Fraud Warnings on page 9)

Signature: _____ Date: _____

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ACCIDENTAL INJURY CLAIM FORM

Insured Information			
Primary Insured Name		Policy Number	
Contact Information	Mailing Address (Street):		
	City:	State:	Zip Code:
	Day Phone:	Email:	
	☐ *Check box if this information is to become a permanent change to your contact information*		

Patient Information			
Patient Name		Patient Date of Birth	____/ ____ / _____
Other Insurance	Does the patient have any other Medical or Supplemental insurance; including, but not limited to Worker's Compensation, Auto, Homeowner's, Medicare, Medicaid or any other State program?		☐ Yes ☐ No
	If yes, carrier type: ☐ Medical ☐ Supplemental ☐ Worker's Compensation ☐ Medicare ☐ Medicaid ☐ Other State Program ☐ Auto ☐ Homeowner's		
	Carrier Name:		
	Carrier Phone Number:		

Injury Information			
Describe how/where the injury occurred			
Date of Injury	___/____ / _____	Date of Initial Treatment for Injury	___/____ / _____
Diagnosis*		*Provide proof of diagnosis (from medical billing or signed Physician's Statement, page 7)	
Other date(s) of Treatment *(Follow-up, Therapy)*			
Was there Hospital Confinement?	If yes, please submit itemized hospital bill including room and board charges		
Was there Ambulance Transport?	If yes, please submit the ambulance bill		
Attending/Treating Physician/Facility for this condition	Primary Physician/Facility:		
	Mailing Address:		
	City:	State:	Zip Code:
	Phone Number:	Fax Number:	

If auto accident, provide the Accident, Incident, or Police Report. Also, please submit any additional medical information or other documentation from your health provider relative to this diagnosis for the review of benefits.

Other Physicians Seen In Past 5 Years			
Other Physicians seen in the last 5 years?*	Name	Reason for Treatment	Phone Number

Please use an additional sheet of paper for claim details, if needed

Please note: Failure to complete all form sections may result in a delay in processing this claim.

Claim Form Fraud Warning

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Signature: _____Date: _____

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Patient Total Disability Income Claim Form

Instructions: Complete the form below if your claim is due to total disability and send in with additional required items.
Please submit the following:

- Have your employer complete the *Employer Total Disability Statement, page 6*
- Have the primary treating physician for your total disability complete the *Physician's Statement, page 7*
- Provide proof of income for the last 12 months prior to disability (can be provided in the form check stubs, tax return, or bank statements)
- Complete the *Claims Authorization for the Release of Information, page 2*
- Attach a copy of the Physician's office notes/medical records supporting each month of disability you are claiming. If you cannot provide this information, it will be obtained on your behalf with the signed *Claims Authorization for the Release of Information*.

NOTE: This Claim Form and information above must be completed and submitted each time a scheduled follow-up with your physician occurs for your disability, or monthly if no follow-up is scheduled with your physician within three months.

Insured Information			
Primary Insured Name		Policy Number	
Contact Information	Mailing Address (Street):		
	City:	State:	Zip Code:
	Day Phone:	Email:	
	☐ *Check box if this information is to become a permanent change to your contact information*		
Patient Information			
Patient Name		Patient Date of Birth	____/ ____ / _____
Other Insurance	Does the patient have any other Medical or Supplemental insurance; including, but not limited to Worker's Compensation, Auto, Homeowner's, Medicare, Medicaid or any other State program?		☐ Yes ☐ No
	If yes, carrier type: ☐ Medical ☐ Supplemental ☐ Worker's Compensation ☐ Medicare ☐ Medicaid ☐ Other State Program ☐ Auto ☐ Homeowner's		
	Carrier Name:		
	Carrier Phone Number:		

Total Disability Details	
Reason for Total Disability (Describe the Illness or Injury):	
Please describe **all** your specific duties during a full work day (including hours of sitting or standing, lifting, or other physical actions):	
Date Condition Began ____/ ____ / _____	Date of Initial Treatment ____/ ____ / _____

Claim Form Fraud Warning

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Patient Signature: _____ Date: _____

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Employer Total Disability Statement

Please complete the information for the employee below.

Employee Information			
Employee Name		Date of Birth	____/____/_____
Job Title		Hire Date	____/____/_____
Employer Information			
Company Name		Industry Type	
Contact Information	Mailing Address (Street):		
	City:	State:	Zip Code:
	Phone:	Email:	

Total Disability Details

Date Employee Last Worked: ____/ ____ / _____	Reason for stopping work: ☐ Sickness ☐ Injury ☐ Laid Off ☐ Dismissed ☐ Other_____	
Prior to the disability, how many hours per week were worked? Part-Time: _____/Hours Full-Time: _____/Hours	Wages	$ _____ Hourly or $ _____ Annual

Has the employee returned to work?

☐ Yes: ☐ Part-Time Date: ____/ ____ / _____ ☐ Full-Time Date: ____/ ____ / _____

☐ No: If No, what is the expected date of return to work? ____/ ____ / _____

Is the Employee's condition work related or did the injury occur on the job? ☐ Yes ☐ No

Has Workers' Compensation or Occupational Disease claim been filed? ☐ Yes ☐ No

Is the Employee allowed to work from their home? ☐ Yes ☐ No

What are the major tasks of the employee's occupation? Indicate the percentage of the employee's workday that is spent on each of these tasks (and submit a job description).

_____ _____%
_____ _____%
_____ _____%

Claim Form Fraud Warning

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Print Name & Title of Person Completing Form _____

Signature of Person Completing Form _____ Date ___/____/_____

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PHYSICIAN'S STATEMENT

(MUST be completed and signed by a Qualified Licensed Physician)

Insured Information		
Patient Name:		Date of Birth: ____/ ____ / _____
Policy Number:		
Physician Information		
Physician Name:		Specialty:
License #:		State:
Office Address:		
Phone Number:		Fax Number:
Claim Details		
Nature of Patient's Condition	☐ Sickness ☐ Injury	Patient's Diagnosis:
Date of Onset	____/ ____ / _____	
Is this the first diagnosis of this condition? ☐ Yes ☐ No		
Date(s) of Service/Procedure		Description
First Visit:	____/ ____ / _____	
Follow-up (if any):	____/ ____ / _____	
	____/ ____ / _____	
Surgery/Test:	____/ ____ / _____	
Has patient been released from treatment? ☐ No ☐ Yes If yes, date released? ____/ ____ / _____		
If patient's condition resulted in total disability, please complete the following section		
Reason for Total Disability:		
Describe the patient treatment plan for recovery:		
In consideration of full work day duties described by the patient, please list any portion, if any, of these duties the patient CANNOT perform:		

Date Total Disability Began	Date of Next Follow-up	Expected Date of Return to Work
____/ ____ / _____	____/ ____ / _____	____/ ____ / _____
Please complete the following section for a total disability follow-up visit		
Has patient's condition improved? ☐ Yes ☐ No If yes, by what percentage? _____%		
Please describe improvements made:		
Is the Patient still disabled?	If no, expected date of Return to Work	If yes, date of next Follow-up
☐ Yes ☐ No	____/ ____ / _____	____/ ____ / _____

Claim Form Fraud Warning

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Physician Signature: _____ Date: _____

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WELLNESS CLAIM FORM

Insured Information			
Primary Insured Name		Policy Number	
Contact Information	Mailing Address (Street):		
	City:	State:	Zip Code:
	Day Phone:	Email:	
	☐ *Check box if this information is to become a permanent change to your contact information*		
Patient Information			
Patient Name		Patient Date of Birth	____/ ____ / _____
Other Insurance	Does the patient have any other Medical or Supplemental insurance; including, but not limited to Worker's Compensation, Medicare, Medicaid or any other State program?	☐ Yes ☐ No	
	If yes, carrier type: ☐ Medical ☐ Supplemental ☐ Worker's Compensation ☐ Medicare ☐ Medicaid ☐ Other State Program		
	Carrier Name:		
	Carrier Phone Number:		
Wellness Exam Information			
Type of Wellness Exam			
Date of Service	____/ ____ / _____		
Please submit the UB04 hospital bill or HCFA 1500 bill received from the health provider's office or other documentation indicating that a wellness exam was performed for the review of benefits.			

Claim Form Fraud Warning

I agree that all statements and answers in this Form are true to the best of my knowledge and belief. I also understand 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. (See State Specific Claim Form Fraud Warnings on page 9)

Signature: _____Date: _____

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STATE-SPECIFIC CLAIM FORM FRAUD WARNINGS

Before signing the claim form, please read the specific warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

AL, AR, CA, LA, MD, NM, RI and WV: 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.
AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
AZ, NJ: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
CO: 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.
DC: 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. An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant
DE, ID, IN and OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
FL: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.
KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NV: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.
NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.
NY: 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 shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.
OH: Any person who, with 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 is guilty of insurance fraud.
OR: Any person who knowingly presents a false statement of claim for insurance may be guilty of insurance fraud and may be subject to criminal and civil penalties.
PA: 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.
TX: Any person who knowingly presents a 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.