1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
   (UB04 OR CMS HCFA1500 Bill)
3. MAIL TO *HSR*

E-mail: UBAclaims@hsri.com

HSR Plaza II
8400 Belleview Drive
Suite 150
Plano, Texas 75024
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (866) 523-3452

Policy Name:
United Business Association
Policy Number:
HASA-BAM-1000

Critical Illness Claim Form

1. Claimant's Name (Insured)	2. Social Security Number	3. Gender ☐M ☐F	4. Date of Birth	5. E-Mail

6. Address of Claimant and Best Contact Phone Number (Include Area Code)

7. If claim is on a dependent please complete the following: ☐ Spouse ☐ Domestic Partner/ Civil Union ☐ Child/Stepchild	8. Dependent's Name	
9. Dependent's Date of Birth	10. Dependent's Social Security Number	11. Dependent's Address if Different

Critical Illness Information

☐ **Invasive Cancer**: A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of local or distant tissue. The term Invasive Cancer also includes Leukemia, Lymphoma and malignant melanoma with a maximum thickness of 10 mm as determined by histological examination using the Breslow Method.

☐ **Heart Attack (Myocardial Infarction):** The death of a portion of the heart muscle resulting from blockage of one or more coronary arteries

☐ **Stroke:** The death of brain tissue due to a cerebrovascular event resulting in neurological damage including infarction, hemorrhage or embolization of brain tissue from an extra cranial source for at least 60 days.

See your policy for complete benefits and exclusions

12. Describe condition or illness

13. Date you were first seen for this condition	14. Confirmed diagnosis date	15. Have you ever been hospitalized for the same or similar condition ☐ Yes ☐ No

16. If Yes to question 15 provide name and address of hospital

17. Reason for prior hospitalization

18. Are you currently hospitalized for your current condition?
☐ Yes ☐ No

19. If yes to question 18 provide name and address of hospital

20. Name and address of treating physician

21. Signature of claimant 22. Date

In order to process your claim additional documentation may be required.
Medical records, pathology reports, office visit notes, EKG scans and/or various other records

Please complete and return page 3 along with this claim form so we may request these documents on your behalf

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

FRAUD WARNING NOTICES

Any person who knowingly presents a false of fraudulent claim for payment of 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.

STATE SPECIFIC PROVISIONS

Alabama	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.
Alaska	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.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas **Louisiana**	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.
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.
Colorado	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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Connecticut	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
Delaware **Idaho**	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia	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. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Hawaii	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
Indiana	A person who knowingly and with intent to defraud an insurer. files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	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.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Michigan **North Dakota** **South Dakota**	Any person who knowingly and with intent to defraud any insurance company or another 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 and subject the person to criminal civil penalties.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty o f a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
New Hampshire	Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA638:20
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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 civil fines and criminal penalties.
Ohio	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.
Oklahoma	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.
Oregon	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
Pennsylvania	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.
Rhode Island **West Virginia**	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.
Tennessee **Virginia** **Washington**	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Texas	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.
Utah	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.

Authorization for Release of Medical Information

Patient Name_____

Date of Birth_____/_____/_____Social Security #_____-_____-_____

I,_____patient of_____(physician name)
am authorizing Health Special Risk, Inc. to use and/or disclose my health information as identified below to:

Name of Provider _____
Address: _____
_____
Phone Number _____
Fax Number _____

For the following purpose(s): Describe each purpose; if requested by the patient, you may state "at patient's request"

_____All Records from_____(date) to_____(date)
_____Initial Exam Records
_____All Office Records
_____All Hospital Records
_____Laboratory / Pathology Reports
_____Billing / Financial Statements

_____(Initials) I DO (____) or I DO NOT (_____) consent to the release of information relating to psychiatric or psychological testing, alcohol and / or drug abuse diagnosis, prognosis and treatment and /or HIV (AIDS) testing and/or results.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

This consent shall become invalid **180** days from the date signed unless a different expiration date, event or condition is specified. Specify:_____

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. I have the right to receive a copy of this authorization.
3. A copy or facsimile of this authorization is as valid as the original.

_____ _____
Signature of Individual or Individual's Legal Representative Date

_____ _____
Print Name or Print Name of Legal Representative Relationship to Individual

Mail To: Health Special Risk, Inc
8400 Belleview Drive, Suite 150
Plano, Texas 75024

or

Fax to: 972-512-5820

Phone: 800-328-1114