VFIS Claims Management

Critical Illness Benefit

National Union Fire Insurance Company of Pittsburgh, PA
New York, New York

INSTRUCTIONS

1. Fully complete the Insured's/Information section. If a section does not apply, or information is not available, write "NA" in the space so that we know you did not overlook that particular question.
2. Read the Fraud Statement and sign in the space provided.
3. Read the HIPAA Authorization section and sign in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. Failure to sign the authorization may delay the processing of your claim.
4. For the Critical Illness benefit, have your attending physician complete the Attending Physician Statement section of the form and attach the pathology report that confirms the diagnosis.
5. Mail, fax, or Email your claim to: WinStar Insurance Group

Tom Newby
13625 Ronald W Reagan Blvd
Bldg 3, Ste. 100
Cedar Park, TX 78613
Fax Number: 512.448.9929
Email: tnewby@winstarins.com

INSURED'S INFORMATION				
Name of Insured (first, middle initial, last) (Please Print)		Social Security Number	Policy Number	
Address, Street & No.		City	State	Zip
Phone No.	Date of Birth	Male ☐ Female ☐		

IF PATIENT OTHER THAN INSURED			
Name (first, middle initial, last) (Please Print)	☐Spouse ☐Child	Date of birth	Social Security Number

ILLNESS INFORMATION	
Type of illness for which this claim is being made	When was the illness diagnosed

Insured's signature:	Date:

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Fraud Statement
P.O. Box 5126, York, PA 17405
Tel +1 800-233-1957 Fax +1 717 747 7051

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FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:
Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits 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, Maryland, New Mexico, Rhode Island, Texas, 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.
California: For your protection California law requires the following to appear on this form: 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.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding and 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 provided 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.
Delaware, Idaho, Indiana, Oklahoma: WARNING – 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, Maine, Tennessee, Virginia, Washington: WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may 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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
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.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
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 RSA 638:20.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil 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.
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.
Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years.
New York: 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 five thousand dollars and the stated value of the claim for each such violation.

Insured's Signature_____ Date _____

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HIPAA Authorization
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Health Insurance Portability and Accountability Act ("HIPAA")

Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number (Insert last 4 digits of SS# only)

I hereby authorize all of the people and organizations listed below to give VFIS Claims Management and their authorized representatives, as well as other agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG Company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG Companies Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: VFIS Claims Management, P.O. Box 5126, York, PA 17405 I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Insured or Insured's Personal Representative Date

_____

Description of Authority of Personal Representative (if applicable)

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ATTENDING PHYSICIAN'S STATEMENT

Patient's name	Date of Birth	Date of Death (if applicable)

Diagnosis

When did signs and/or symptoms first appear?	Has the patient ever received medical advice or treatment for this or a similar condition?
	☐ Yes, when_____ ☐ No

Date of diagnosis (the date the pathological specimen(s) were obtained on which illness was diagnosed)	Stage: ☐0 ☐1 ☐2 ☐3 ☐4 T: ☐X ☐0 ☐1 ☐2 ☐3 ☐4 N: ☐X ☐0 ☐1 ☐2 ☐3 M: ☐X ☐0 ☐1	Was the illness ☐ Pathologically diagnosed, or	☐ Clinically diagnosed

Attach a copy of the pathology report, EKG, imaging and any scans that supports the diagnosis:

Does patient suffer from any chronic condition:

Does patient take any prescriptions regularly?

ABOUT THE PHYSICIAN(S) AND HOSPITAL(S)

Primary Care Physician Name	Specialty	Date of first visit for this condition
Address	City	State and Zip Code
Phone No.	Fax No.	
Treating Physician Name	Specialty	Date of first visit for this condition
Address	City	State and Zip Code
Phone No.	Fax No.	

Hospital Name

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ABOUT THE PHYSICIAN(S) AND HOSPITAL(S) con't	
Address, City, State and Zip Code	
Date Admitted	Date Discharged
Phone No.	Fax No.

ATTENDING PHYSICIAN'S SIGNATURE			
I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.			
Name (attending physician) please print	Degree	Telephone number	
Address	City	State	Zip
Signature	Date	Medical State License#	