MEMBER BENEFITS
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Working to Benefit You

GROUP CATASTROPHE MAJOR MEDICAL PLAN CLAIM FORM

INSTRUCTIONS

1) Fully complete the Insured/Claimant's Information section and sign in the space provided.

2) Read the Fraud Statement and sign in the space provided.

3) Review and sign the two (2) HIPAA Authorization Forms. The authorizations will assist the Claim Administrator to obtain any additional information needed to complete the processing of your claim. Failure to provide the authorizations may delay the processing of your claim.

4) Include the following supporting documents (if applicable):
   - Corresponding statements of payment or denial from **all** other insurance carriers, commonly known as an Explanation of Benefits (EOB);
   - Itemized invoices from your health care providers. This will provide the Claim Administrator with information important to your claim.

Important: Claims must be filed within five (5) years of incurring the claim expense.

CLAIM PROCESSING INFORMATION

- If your benefit period effective date is 12/31/13 or before, the CMM Plan Certificate of Insurance (Policy # E-610,219) underwritten by the United States Life Insurance Company in the City of New York remains in effect.
  - Mail your claims to: The United States Life Insurance Company in the City of NY
    P.O. Box 1581, MSN 2-E
    Neptune, NJ 07754-1581
    Questions: 800-348-6908

- CMM Plan Document (Policy #: CMMI-002) sponsored by NYSUT Member Benefits Trust is in effect for benefit period effective dates 1/1/14 or beyond.
  - Mail your claims to: Mercer Consumer
    P.O. Box 14437
    Des Moines, Iowa 50306-3437
    Questions: 888-386-9788

INSURED/CLAIMANT INFORMATION SECTION

Name of Insured (first, middle initial, last) (Please Print)			Social Security Number	Policy Number **CMMI-002**	
Insured's Address, Street & No.			City	State	Zip
Single ☐ Divorced ☐ Other ☐ Married ☐ Widowed ☐	Date of Birth	Male ☐ Female ☐	Home Phone	Daytime Phone	
Patient's Name for whom claim is being made (first, middle initial, last)				Patient's Relationship to Insured	
Patient's Address, Street & No.			City	State	Zip
Patient's Gender Male ☐ Female ☐	Patient's Date of Birth	Single ☐ Married ☐	Is Patient Employed? Yes ☐ No ☐		
Is the patient eligible for coverage under an employer-sponsored health plan? Yes ☐ No ☐					

MEMBER BENEFITS

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INSURED/CLAIMANT INFORMATION SECTION
Continued

Nature of Patient's Sickness or Injury			
If related to an injury, how, when and where did the injury occur?			
If hospitalized, give name and address of hospital			Dates of confinement
Attending Physician's Name			
Attending Physician's Address, Street & No.	City	State	Zip
Attending Physician's Telephone Number			

Please indicate by checking yes or no and providing the policy number if you and/or the patient have coverage under any of the following plans.

Medicaid - Yes ☐ No ☐ Policy #_____ Effective Date: _____

Medicare - Yes ☐ No ☐ Policy #_____ Effective Date: _____

United - Yes ☐ No ☐ Policy #_____ Effective Date: _____

BlueCross - Yes ☐ No ☐ Policy #_____ Effective Date: _____

CSA - Yes ☐ No ☐ Policy #_____ Effective Date: _____

GHI - Yes ☐ No ☐ Policy #_____ Effective Date: _____

S.H.I.P. - Yes ☐ No ☐ Policy #_____ Effective Date: _____

AARP - Yes ☐ No ☐ Policy #_____ Effective Date: _____

RSSA - Yes ☐ No ☐ Policy #_____ Effective Date: _____

Please list all other coverages you and/or the patient may have. If space is not adequate, use separate page.

Insurance Co. Name & Address: _____

Policy #_____ Effective Date: _____

Insurance Co. Name & Address: _____

Policy #_____ Effective Date: _____

Insurance Co. Name & Address: _____

Policy #_____ Effective Date: _____

IMPORTANT NOTICE: It is unlawful for any person to knowingly, and with the intent to defraud, present, or cause to be presented, or prepare with the knowledge and belief that it will be presented to a self-insurer, a claim for payment, containing any materially false information concerning any material fact related to such claim, or to conceal, for the purpose of misleading, information concerning any material fact related to such claim (collectively, "Unlawful Acts"). Such Unlawful Acts may also lead to a denial of benefits from this Plan.

_____ _____

Signature of Insured Date

American General
Life Companies

FRAUD WARNING

This fraud warning applies to the CMM Plan Certificate of Insurance (Policy # E-610,219) which remains in effect for benefit period effective dates 12/31/13 or before.

In some states we are required to advise you of the following: any person who knowingly intends to defraud or facilitates a fraud against an insurer by submitting an application or filing a false claim, or makes an incomplete or deceptive statement of material fact, may be guilty of insurance fraud.

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.
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.
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.

Signature of Insured

Date

American General
Life Companies

HIPAA Authorization Section
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give The United States Life Insurance Company in the City of New York and the American General Life Companies LLC, (an affiliated service company), collectively the "Companies", 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 American General Life Companies 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 American General Life 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: The United States Life Insurance Company in the City of New York, P.O. Box 1581, MSN 2-E, Neptune, New Jersey 07754. 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 Claimant or Claimant's Personal Representative

Date

Description of Authority of Personal Representative (if applicable)

MEMBER BENEFITS
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Working to Benefit You

HIPAA Authorization Section
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give NYSUT Member Benefits Trust ("Trust"), and their authorized representatives, including its administrator, Mercer Consumer, as well as other agents and insurance support organizations, (collectively, the "Recipients"), 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;
- 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 Recipients 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 Recipients listed above are subject to federal privacy regulations. I understand that information released to the Recipients will be used and disclosed as described in the Trust's HIPAA Privacy Notice, 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 Recipients to contest a claim under the policy or to contest the policy itself, by sending a written request to: Mercer Consumer, PO Box 10362, Des Moines, IA 50306-0362. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipients 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 Recipients 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 Claimant or Claimant's Personal Representative | Date

_____

Description of Authority of Personal Representative (if applicable)