KEMPER Health

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 9988
Austin, TX 78766-9988
Telephone: 844.613.6245 Fax: 844.473.8084
Email: service@kemperbenefits.com Website: kemperbenefits.com

CLAIM FORM – CANCER/SPECIFIED DISEASE COVERAGE

Instructions to File a Claim:

- Please complete Insured/Claimant Statement and mail, fax or email the completed form to the address or fax number indicated above.
- To verify 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, fax or email 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)	Email Address

Claimant's Name (Person who is sick)	Date of Birth	Relationship to Insured

Nature of Cancer/Covered Specified Disease	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 Admission date: Discharge date:	Please provide name and address of hospital:

Have you ever been treated for or diagnosed as having had the above listed medical condition prior to the effective date of this policy? ☐ Yes ☐ No If yes, when?

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN 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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Attending Physician's Statement – Cancer/Specified Disease Coverage

(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 10 codes)	When did symptoms first appear?	When did the patient first consult you for this condition?

CANCER

Please circle if cancer was pathology diagnosed or clinically diagnosed.

Date of Diagnosis:_____

Has the patient ever had the same or similar condition? YES☐ NO☐

(If Cancer was pathologically diagnosed, please attach a copy of the pathology report. If the Cancer was clinically diagnosed, please provide the reasons that pathological diagnosis was not obtained and attach medical documentation that supports the diagnosis of Cancer.)

HEART ATTACK

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.)

SPECIFIED DISEASE

Please check applicable condition:

☐ Addison's Disease	☐ Amyotrophic Lateral Sclerosis	☐ Cystic Fibrosis	☐ Diphtheria
☐ Encephalitis	☐ Epilepsy	☐ Hansen's Disease	☐ Legionnaire's Disease
☐ Lupus Erythematosus	☐ Lyme Disease	☐ Malaria	☐ Meningitis (epidemic cerebrospinal)
☐ Multiple Sclerosis	☐ Muscular Dystrophy	☐ Myasthenia Gravis	☐ Niemann-Pick Disease
☐ Osteomyelitis	☐ Poliomyelitis	☐ Rabies	☐ Reye's Syndrome
☐ Rheumatic Fever	☐ Rocky Mountain Spotted Fever	☐ Scarlet Fever	☐ Sickle Cell Anemia
☐ Tay-Sachs Disease	☐ Tetanus	☐ Toxic Epidermal Necrolysis	☐ Tuberculosis
☐ Tularemia	☐ Typhoid Fever	☐ Undulant Fever	☐ Whipple's Disease

Date of Diagnosis: _____

(Please provide clinical documentation)

STROKE

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.

Address: Street, City, State, Zip	Tax Identification No.