ESC
Essential StaffCARE

ANCILLARY CLAIM FORM
Send this claim form to:
Planned Administrators Inc.
Attn: Claims
P.O. Box 6702, Columbia, SC 29260-6702

GROUP ANCILLARY CLAIM FORM

Use this claim form to submit a claim for ESC Group Accident Indemnity and/or Critical Illness.

IMPORTANT CLAIM FILING INSTRUCTIONS:

- Please review carefully and fully complete the form. An incomplete form will delay the processing of the claim.
- All claims must complete sections 1, 2, 4, 7, and 8.
- Complete the portion related to the product for which you are filing a claim:
    - 3A – Accident Indemnity
    - 3B – Critical Illness
- **Enclose supporting documentation with your claim form.** Supporting documentation may include: medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical/hospital bills, medical EOBs, toxicology reports, childcare/transportation/lodging receipts, or police reports (if applicable following an accident).
- Submit the form and supporting documentation to:

    Planned Administrators Inc.
    Attn: Claims
    P.O. Box 6702
    Columbia, SC 29260-6702

Questions? Call our toll-free Customer Service Line, 1-888-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time.
A language line is available for translation for most languages.

SECTION 1 – EMPLOYEE/POLICYHOLDER INFORMATION

Provide details of the policyholder and insured

Employer Name _____

Group Policy Number _____

Employee/Insured Name *(First Name, Middle, Last Name)* _____

SSN or Tax ID # _____

Gender ☐ Male ☐ Female

Address *(Street, City, State & Zip)* _____

Date of Birth *(mm/dd/yyyy)* _____

E-mail Address _____

Phone Number _____

Cell/Mobile Number _____

Do you authorize the delivery of confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No

Via e-mail? ☐ Yes ☐ No

If Yes to either personal cell phone or e-mail, please **initial here** to confirm your response: _____

Does the employee/insured have major medical insurance or other primary health insurance? ☐ Yes ☐ No
If Yes, provide name of insurance carrier and policy number: _____

Is the employee/insured currently actively working? ☐ Yes ☐ No
If No, date last worked and reason: _____ **Hours Worked/Week:** _____

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SECTION 2 – CLAIMANT/PATIENT INFORMATION

Complete if this claim is for a dependent of the employee/insured

☐ Patient is same as policyholder (if you check this box, you may skip to **Section 3 or Section 5 for Wellness Claims**)

Claimant/Patient Name *(First Name, Middle, Last Name)* _____

Date of Birth *(mm/dd/yyyy)* _____

SSN or Tax ID # _____

Relationship (To Employee/Insured) _____

E-mail Address _____

Phone Number _____

Cell/Mobile Number _____

Check all that apply – I authorize the delivery of confidential medical or benefit information via personal cell phone and/or email?
☐ Personal cell phone ☐ Email. ☐ None

If Yes to either personal cell phone or e-mail, please **initial here** to confirm your response: _____

Complete Mailing Address *(Street, City, State & Zip)*

_____

Is the child incapacitated/disabled? ☐ Yes ☐ No **Is the child married or in a partnership?** ☐ Yes ☐ No

SECTION 3A – ACCIDENT CLAIM DETAILS

Complete this section if filing a claim for the Accident policy only.

Date/Time of the Accident?

Location of Accident (Place, Street, City, State, Zip)

_____

Who was involved in the accident? Select all that apply. ☐Employee/Member ☐Spouse ☐Child(ren)

Was this a motor vehicle accident? ☐ Yes ☐ No

Was there a legal agency investigation? ☐ Yes ☐ No If yes, provide Agency Name_____
Please enclose a copy of the report with Form.

Did the Accident happen at work? ☐ Yes ☐ No If yes, will or has a Workers Comp Claim been filed? ☐ Yes ☐ No

Was the injury a result of participating in an Organized Sport activity? ☐Yes ☐No If yes, provide details of the activity and organization
_____

Was Death a result of this accident or injury? ☐Yes ☐No If yes, please enclose a copy of death certificate and legal documentation verifying the person authorized to handle the affairs of the deceased along with your Claim Form submission.

Please provide a detailed explanation of how the accident occurred.

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SECTION 3B – CRITICAL ILLNESS CLAIM DETAILS

Complete this section if filing a claim for the Critical Illness policy only.

What is the Critical Illness for which the claim is being made?

When was the Critical Illness first diagnosed? Has the claimant ever had this same or similar condition? ☐ Yes ☐ No

Check the box that applies to this Critical Illness: ☐ Initial/Additional Critical Illness ☐ Recurrent Critical Illness

Please provide a detailed explanation of the diagnosis.

Section 4 - ATTENDING PHYSICIAN STATEMENT

Complete this section for all Accident, Critical Illness, and/or Hospital Indemnity claims.

Please return completed form to your patient. The patient/insured is responsible for securing this form and supplying as part of claim submission.

Patient Name _____

Diagnosis of Condition (including ICF or DSM code)

_____

When did symptoms first occur or accident happen? _____

When did the patient first consult you for this condition or accident? _____

If the patient previously received medical treatment, please provide the physician's/hospital's name and address.

_____

List the dates of treatment and charges for each visit (including procedure codes):

_____

If the patient was hospitalized, please give the name and address of the hospital, and dates of confinement.

_____

Has the patient ever been treated for this condition prior to this time? ☐ Yes ☐ No

If yes, provide dates and prior diagnosis/treatment. _____

Physician Name (Print)

_____

Signature _____

Date _____

Street Address City State Zip _____

Telephone Number _____

FRAUD NOTICES

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: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive 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. Penalties may include imprisonment, fines, denials of **insurance** and civil damages.

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 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.

Delaware, Idaho, Indiana and Oklahoma: 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.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

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 a denial of insurance benefits.

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 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.

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.

Oregon: Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be 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 to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia and 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.

All Other States Not Listed Separately: 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.

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SECTION 5 – CLAIMANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:
I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, insurance company, or insurance support organization that has such information, to disclose the following health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to BCS Insurance Company (BCS) and any representatives performing services for BCS, including its insurance support organizations, third-party administrators, affiliates, and any reinsurers. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask BCS to correct, amend or delete any incorrect personal information.

I acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. A copy of BCS' "Notice of Privacy Practices" is available upon request.

This authorization shall be valid for a period of 24 months from the date signed (in AZ, 180 days) (in VA, 30 months). A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to BCS' Administrative Office.

Although my signature on this form is voluntary, I understand that it is required to determine my eligibility for benefits under an insurance policy issued by BCS. Without my signature, or upon its revocation, I understand that my claim for insurance benefits may be denied. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. However, BCS does require its agents and service providers to protect the confidentiality of health information.

My signature below represents my acknowledgement, acceptance and authorization for all statements above.

Print Claimant Name	**Date of Birth**	**Social Security Number**
Claimant Signature *(if claimant is over age 18)*	**Date**	
Signature of Legal Guardian *(if claimant is under age 18)*	**Date**	
Print Name of Legal Guardian *(if signing for claimant above)*	**Relationship to Claimant**	**Legal Guardian Address & Phone Number**

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OPTIONAL CLAIMANT AUTHORIZATION TO RELEASE INFORMATION REGARDING THIS CLAIM

Please initial below in the spaces provided if you wish to allow us to release information to a particular entity inquiring about this claim on your behalf. Any other marks used (check mark, X, etc.) cannot be accepted and will be processed as if blank. Leave blank if you do not want us to release any information to a particular entity. You must also sign and date this page in the spaces provided below.

I authorize BCS Insurance Company and its Administrative Office to facilitate the processing of this claim by releasing its details, including Protected Health Information (PHI), to the following entity or entities inquiring on my behalf:

INITIALS	Agent	INITIALS	Employer Insurance Administrator
INITIALS	Spouse/Domestic Partner	INITIALS	Other (specify name and relationships):

Claimant Signature *(if age 18 or over)* **Date**

Print Claimant Name

Employee/Insured Signature *(if claimant is under age 18)* **Date**

Print Employee/Insured Name **Policy Number**

Dates of Hospital Confinement (mm/dd/yyyy – mm/dd/yyyy)

SECTION 6 – CLAIMANT CERTIFICATION AND SIGNATURE

Claimant Certification

By signing below, I hereby certify that:

1. The information provided on this form is true and complete to the best of my knowledge and belief; and
2. I have read and understand the "Important Notice—Fraud Warning Statements" that applies to my state of residence.

Claimant Signature **Date of Signature**

Mail or fax completed Claim Form, along with supporting documentation, to:
Planned Administrators Inc.
Attn: Claims
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