



1. PLEASE FULLY COMPLETE THIS FORM  
 2. ATTACH ITEMIZED BILLS  
 3. MAIL TO HSR  
 E-mail : [claims@hsri.com](mailto:claims@hsri.com)

HSR Plaza II  
 4100 Medical Parkway  
 Carrollton, Texas 75007  
 Phone: (972) 512-5600 Fax: (972) 512-5820  
 Toll Free (866) 523-3452

Policy Name:  
**United Business Association**  
 Policy Number:  
**GAH - 022**

## Critical Illness Claim Form

1. Claimant's Name (Insured)	2. Social Security Number	3. Gender <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner / Civil Union <input type="checkbox"/> 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 neoplasm characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue

**Heart Attack (Myocardial Infarction):** The death of a portion of the heart muscle as a result of inadequate blood supply

**Stroke:** A cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than 24 hours and resulting measurable neurological deficit persisting for at least 30 days after the occurrence of the stroke

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. If Yes to question 16 provide name and address of hospital		
17. Reason for prior hospitalization		
18. Are you currently hospitalized for your current condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. If yes to question 17 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

## FRAUD STATEMENTS

### FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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.

**Alaska and 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, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and 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, West Virginia & Rhode Island : Warning:** 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 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.

**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, Indiana:** 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: WARNING :**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.

**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.

**Georgia:** Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:

- a) In any written statement;
- b) In the filing of a claim; or
- c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;

3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or

4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

**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.

**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 subjects the person to criminal and 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 of 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 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 and 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.

**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.

**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:** Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

**Tennessee, Virginia, Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes 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.

# 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**  
**4100 Medical Parkway**  
**Carrollton, Texas 75007**

or

**Fax to: 972-512-5820**

**Phone: 800-328-1114**