200 SW Market Street, Suite 800
Portland, OR 97201

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free: 1 (800) 286-1129
Fax: (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Statement of Critical Illness

Insured's Statement

Information about Patient

Name of Patient (Last, First, Middle Initial) ☐ Member ☐ Spouse ☐ Domestic Partner ☐ Dependent Child	Date of Birth	☐ Male ☐ Female
Mailing Address Street & Number City State Zip		Primary Phone Number ( )

Information about Employee/Primary Insured

Name of Member, if not the patient (Last, First, Middle Initial)		Date of Birth	Social Security Number
Mailing Address Street & Number City State Zip			☐ Male ☐ Female
Home Phone Number ( )	Cell Phone Number ( )	Employer/Association	Policy Number

Information regarding the Critical Illness

Nature of Illness:	Date of First Treatment
Please describe your symptoms. (If you need more space, please attach a separate sheet of paper.)	
Have you ever had this or a similar condition before? ☐ Yes ☐ No If yes, please provide the date: _________________ and the name and address of treating physician:	

Information about Physicians and/or Hospital

Full name of treating physician		Specialty
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )
Full name of primary physician		Specialty
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )
Full name of referring physician/hospital		
Mailing Address (street, city, state, zip)	Phone Number ( )	Fax Number ( )

Instructions

1. Please make sure all questions on the Statement of Critical Illness form are completed in full.
2. Authorization to Obtain and Release Information form must be signed and dated.
3. The Attending Physician Statement on page 4 must be completed, signed and dated.

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.
I acknowledge that I have read the fraud notice on page 2 of this form.

▶ ____ ▶ ______________________
Employee's Signature Date

Please complete page 3.

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Insurance Fraud Warning

Unless specific state language is provided below, the following general fraud notice applies: 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.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 Residents: 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.

District of Columbia Residents: 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 Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: 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.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 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.

Puerto Rico Residents: 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.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment for 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.

Maine, Tennessee, Virginia and Washington Residents: 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.

Alaska, Kansas and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: 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.

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Authorization to Obtain and Release Information

I authorize persons or entities having any records or knowledge of me or my health, including any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer:

To give Medical information including chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results and prognosis with respect to any physical or mental condition and/or treatment of me, excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records which may have been acquired in the course of examination or treatment.

If the information to be disclosed contains any of the types or information listed below, additional laws relating to the use and disclosure may apply. I understand and agree that this information will be used or disclosed only if I place my initials in the applicable space next to the type of information:

________ Drugs/Alcohol diagnosis, treatment or referral information
________ Mental Health information – including provider notes
________ HIV/AIDS information
________ Genetic Testing Information

To LifeMap Assurance Company (LifeMap) and to its authorized representatives.

- I understand that the information obtained by use of this authorization will be used by LifeMap and authorized representatives to evaluate and adjudicate my current claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing LifeMap solely to assist with the evaluation and adjudication of my current claim.
- I understand that LifeMap complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to LifeMap may be subject to redisclosure and may no longer be protected under the Health Information Portability and Accountability Act (HIPAA).
- I understand that I have the right to revoke this authorization by notifying LifeMap in writing, of my revocation. However, such revocation is not effective to the extent that LifeMap has relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair the ability of LifeMap to evaluate my current claim and as a result may be a basis for denying that current claim for benefits.
- I acknowledge that I have read this authorization. I understand and agree that this authorization shall remain in force for the duration of my claim(s) or 12 months, whichever occurs first. A photocopy or facsimile of this authorization is as valid as the original. I understand that I, or my authorized representative, have the right to request and receive a copy of this authorization and the information to which it pertains.

▶ ____ ▶ ______________________
Patient's Full Name (please print clearly) Date Signed

▶ ____ ▶ ______________________
Patient's Signature (or Parent/Guardian) Relation to Patient

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Statement of Critical Illness

Attending Physician's Statement

This statement must be filled-in completely by a physician without expense to insurance company.

Patient Information

Name of Patient (Last, First, Middle Initial)	Social Security Number	Date of Birth
Name of Primary Insured, if not the Patient (Last, First, Middle Initial)	Social Security Number	Employer Name

Information about Diagnosis (Please answer all questions and attach copies of confirming diagnostic reports.)

Diagnosis		ICD Code(s)
Date symptoms first appeared	Date patient first consulted you	Date diagnosis of critical illness was first made

Has patient ever had the same or a similar condition? ☐ Yes ☐ No
If yes, provide brief details including dates of treatment:

Have you treated this patient for other conditions? ☐ Yes ☐ No
If yes, give dates, diagnosis codes and briefly describe treatment:

Was patient referred to you? ☐ Yes ☐ No If yes, please provide name, specialty and address of referring doctor:

Is patient currently being treated for this diagnosis or any related diagnosis by any other health care provider? ☐ Yes ☐ No
If yes, please include name, specialty and addresses of other treating health care providers:

Information about Hospitalization (Please attach copies of hospital discharge summaries.)

☐ Inpatient ☐ Outpatient ☐ N/A	Admission Date	Discharge Date	Describe reason for hospitalization and indicate procedures performed:

Hospital or Facility Name	Phone Number ( )
Mailing Address (street, city, state, zip)	Fax Number ( )

Information about Physician

Physician's Name (Please Print)	Degree/Specialty			Phone Number ( )
Office Address	City	State	Zip	Fax Number ( )

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 5 of this form.

▶ ______________________________ ▶ ______________________
Attending Physician's Signature Date

Please return completed form to your patient.

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