MEDMUTUAL PROTECT®
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY
P.O. Box 14327 Reading, PA 19612-4327
Telephone: 855.521.9345 Fax: 610.374.6986
Email: MedMutualProtect.com/Group

CRITICAL ILLNESS CLAIM FORM

Instructions to File a Claim:

- Claims must be submitted within 1 (one) year from the date of service.
- Please complete Claim Form 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.
- Please review your certificate for benefits that may be applicable.

Insured/Claimant Information				
Insured's Name *(Last, First, Middle)*	Policy/Certificate #	Social Security No.	Date of Birth	Sex
Address *(Street, City, State, Zip)*				
Phone Number *(With Area Code)*	Email			
Claimant's Name *(Person who is sick)*	Date of Birth	Relationship to Insured		

Critical Illness Diagnosis Information	
Nature of illness:	Date of Diagnosis:
When did symptoms first appear?	Date first treated?
Have you ever been diagnosed with the same or similar condition? ☐ Yes ☐ No	Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? ☐ Yes ☐ No If yes, when?_____
Name and address of physician: (list all physicians consulted)	

Non-Local Transportation and Lodging (outpatient)		
Did claimant travel more than 50 miles one way for outpatient treatment for this condition? ☐ Yes ☐ No		Name and address of physician/facility:
Outpatient Treatment Dates: _____		
☐ Transportation: ☐ Auto ☐ Plane *(Attach copy of ticket)*	☐ Lodging: *(Provide lodging receipt/proof of lodging. Must include dates of stay, name, and address of lodging facility.)*	

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Family Member Transportation and Lodging (inpatient)

Was claimant confined to a hospital for this condition, more than 50 miles one way from the claimant's legal address? ☐ Yes ☐ No	Please provide name and address of hospital:
Admission Date: _____ Discharge Date: _____	
Immediate Family Member's Name:	Immediate Family Member's Relationship to Insured:
☐ Transportation: ☐ Auto ☐ Plane *(Attach copy of ticket)*	☐ Lodging: *(Attach receipt/proof of lodging. Must include dates of stay, name, and address of lodging facility.)*

Second Opinion

Was surgery or treatment recommended by a Physician? ☐ Yes ☐ No	Please provide name and address of second Physician:
Did the Insured Person choose to obtain an evaluation with a second Physician? ☐ Yes ☐ No	

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.

INSURED'S SIGNATURE:		DATE:	
CLAIMANT'S SIGNATURE:		DATE:	

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Critical Illness Attending Physician's Statement

Must be completed by physician. Please complete all applicable questions and provide copies of the supporting documentation.

Patient Information			
Patient's Full Name		Policy or Certificate Number	Date of Birth

Diagnosis? *(ICD 10 code)*	Date of Diagnosis?	When did symptoms first appear?	When did the patient first consult you for this condition?

All Diagnoses Not Listed Below
Please attach copies of medical records documenting diagnosis.

Advanced Alzheimer's Disease / Advanced Parkinson's Disease / Huntington's Disease / Multiple Sclerosis (MS) / Severe Arthritis / Severe Osteoporosis		
☐ Clinical diagnosis information *(Please attach copies of medical records documenting diagnosis)*	Does patient require substantial physical assistance from another adult to perform Activities of Daily Living. ☐ Yes ☐ No	If yes, number required? ☐ 2 ☐ 3

Cancer		
☐ Pathologically diagnosed *(Please attach a copy of the pathology report.)*	☐ Clinically diagnosed *(Please provide the reasons that pathological diagnosis was not obtained and attach medical documentation that supports the diagnosis of Cancer.)*	Has patient ever had the same or similar condition? ☐ Yes ☐ No

Coma	
Was the patient in a continuous state of unconsciousness for at least 7 days? ☐ Yes ☐ No	Was the coma medical induced or the direct result of alcohol or drug use? ☐ Yes ☐ No
(Please attach copies of medical records documenting diagnosis.)	

Complete Loss of Hearing / Sight / Speech	
☐ Clinical diagnosis information *(Please attach copies of medical records documenting diagnosis)*	Is the loss of hearing/sight/speech total and irreversible? ☐ Yes ☐ No

Coronary Artery Disease	
Type of Procedure: ☐ Bypass ☐ Angioplasty or Atherectomy *(Please provide operative report.)*	Date of Procedure: _____

End-Stage Renal (Kidney) Failure	
Has the patient undergone peritoneal dialysis on at least a weekly basis? ☐ Yes ☐ No	Has a kidney transplant been recommended? ☐ Yes ☐ No
(Please attach copies of medical records documenting diagnosis and frequency of dialysis.)	

Heart Attack	
Were there new EKG findings consistent with myocardial infarction? ☐ Yes ☐ No	Did the patient show elevation of cardiac enzymes above standard laboratory levels of normal? ☐ Yes ☐ No
(Please attach copies of EKG, lab results, and other diagnostic test results.)	

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Major Organ Failure		
Has a transplant been recommended? ☐ Yes ☐ No	Type of transplant recommended: ☐ Kidney ☐ Heart ☐ Heart-Lung ☐ Lung ☐ Liver ☐ Pancreas	Date of Procedure: _____ *(Please provide operative report.)*
Severe Burns		
Third degree burns? ☐ Yes ☐ No	Percent of total body surface affected: _____	
(Please attach copies of medical records documenting diagnosis.)		
Stroke		
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.)		
Transient Ischemic Attack (TIA)		
Has Stroke prevention treatment been recommended? ☐ Yes ☐ No	Was impairment focal and confined to an area of the brain perfused by a specific artery? ☐ Yes ☐ No	
(Please attach copies of all documented neurological deficits and confirmatory neuron-imaging studies.)		
Attending Physician Signature		
Physician's Name (please print):	Signature:	
Tax ID Number:	Phone:	Fax:
Address: Street, City, State, Zip		