Liberty Insurance Underwriters Inc.
P.O. Box 66400 London, KY 40741
1-877-501-2467
AH_Claims@LibertyMutual.com

How to Complete and File Group Critical Illness Claims

Please use this form to submit Group Critical Illness claims, following the instructions below. We will evaluate your claim based on the terms and conditions of your insurance coverage. If we need additional information or documentation, we will contact you.

Please review your certificate to see your specific benefits. If you have questions, call us toll-free at 1-877-501-2467 or send an email to AH_Claims@LibertyMutual.com.

1. **Carefully read the applicable fraud warning notice on page 2.**
2. **Have the patient read and sign the authorization on page 3. If you are an authorized representative, include a copy of the legal document(s) authorizing you to act on the patient's behalf.**
3. **Complete Parts I-III on page 4.**
   - ✓ Include completed and signed claim forms for each patient and each diagnosis.
   - ✓ Include results of tissue specimens, cultures, and/or titers and other diagnostic studies, which were used to initially diagnose the critical illness.
   - ✓ Attach a copy of each of the following document(s) to this claim form when applicable:
     - A copy of the patient's Explanation of Benefits.
     - Itemized hospital, clinic, facility or physicians' bills, showing date(s)of service, type of service, place of service, and diagnosis (ICD-10) and procedure (CPT) codes.
     - A copy of the patient's hospital admission and discharge papers.
     - Operative reports from all surgeries related to this claim.
4. **Complete Part IV on page 5.**
   Have the patient's attending physician complete and sign this form, and attach it to your claim form.
5. **Submit your completed form and required documentation by mail or email:**

   Mail: Liberty Insurance Underwriters Inc.
   P.O. Box 66400
   London, KY 40741

   Email: AH_Claims@LibertyMutual.com

The acceptance of a claim form by an insurance company is not an admission of coverage, nor does it recognize the validity of any claim.

FRAUD WARNING NOTICE

For states not 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.

State	Notice
Alaska	A person who knowingly and with intent to injure, defraud, or deceive 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.
Arkansas, Louisiana Rhode Island West Virginia	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.
Alabama	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 restitution fines and confinement in prison, or any combination thereof.
California	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	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, and 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	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.
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 or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
Indiana	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 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.
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 Jersey	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and 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 NH Rev. Stat. Ann. §638:20.
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 p erson 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 $5,000 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	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance may be guilty of a crime, and may be subject to fines and confinement in prison.
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.
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.

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Authorization for the release of information, including protected health information

I hereby authorize the use or disclosure of information about me as described below:

1. **Person(s) or group(s) of persons authorized to use or disclose the information:**
   Any physicians, medical practitioners, hospitals, clinics, HMOs, long-term care facilities, medical or medically-related facilities, insurance companies, current or former employers, MIB, Inc., and insurance support organizations.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive the information:**
   The particular company in the Liberty Mutual Group of companies to which I am submitting a claim and its authorized representatives, agents and/or employees and other organizations providing claims management services.
3. **Description of the information that may be used or disclosed:**
   This authorization specifically includes the release of all information related to:
   - ✓ My physical and mental health and my insurance policies and claims, including but not limited to those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding communicable or infectious conditions, including HIV/AIDS.
   - ✓ Personnel records and other work-related information.
4. **Information will be used or disclosed only for the following purpose(s):**
   For investigating, evaluating and processing my claim, and/or for claims-related functions.

Statements of understanding & acknowledgment:

- ✓ I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure as necessary by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.
- ✓ I understand that I may revoke this authorization in writing at any time by sending a written revocation to the company in the Liberty Mutual Group of companies to which I have submitted a claim, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides the Company with the right to contest a claim. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and health care operations.
- ✓ I understand that authorizing the disclosure of my health information is voluntary and the provision of health care services to me is not conditioned on whether I sign this authorization. If I choose not to sign this authorization, payments of benefits may be denied or delayed.
- ✓ This authorization shall remain in force for 24 months from the date of signing, except to the extent applicable state law imposes or allows a different duration. The information obtained under this authorization will be retained in accordance with the Company's standard retention policy and applicable law.
- ✓ I understand that I may request a copy of this authorization.

Printed name of individual/authorized representative		Date
Signature		Date
Description of authority of authorized representative:		
Date of birth:	Claim number:	
Street address:		
City:	State:	ZIP code:

A copy of this authorization will be considered as valid as the original.

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Liberty Mutual INSURANCE

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PART I - Member information		
Member name *(Last, First, Middle Initial)*:		Certificate number:
Address ***(Street, City, State, Zip Code)***:		Social Security Number:
Home phone:	Work phone:	Cell phone:
Email address:		Date of birth:
Occupation:		Gender: ☐ M ☐ F

PART II - Patient information	
Patient: ☐ Member *(If you check this box, skip to Part III)* ☐ Spouse ☐ Dependent Child	Gender: ☐ M ☐ F
Patient name *(Last, First, Middle Initial)*:	Social security number:
Address *(Street, City, State, Zip Code)*:	
Home phone: Work phone:	Cell phone:
Email address:	Date of birth:

PART III- Claim details	
Please describe your illness:	
When did symptoms first appear?	
Have you ever had the same or similar condition? ☐ Yes ☐ No	If yes, when?
Were you hospitalized for this illness? ☐ Yes ☐ No	Hospital name:
Admission date:	Discharge date:

Please attach supporting Explanation of Benefits, medical reports (see page 5), operative reports, hospital admission and discharge papers, itemized hospital bills and second opinion physician's bills, if applicable.

Printed name of member or authorized representative	If signed by authorized representative, describe legal relationship.
Signature of member or authorized representative:	Date:

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PART IV – Attending physician statement

Patient name: *(Last, First, Middle Initial)*:	Patient's date of birth:
Diagnosis *(include concurrent conditions)*:	ICD-10 code:
Diagnosis type: ☐ Initial diagnosis ☐ Additional diagnosis ☐ Recurring diagnosis	Is this diagnosis work related? ☐ Yes ☐ No

Please check all conditions that apply to this patient. Also, provide test results, operative reports, pathology reports and your detailed medical statements as indicated below for each condition.
NOTE: A DIAGNOSIS FROM A SPECIALIST IN THE APPROPRIATE FIELD FOR EACH CONDITION IS REQUIRED.

☐ **Benign brain tumor**
Pathological report

☐ **Blindness** *(initial diagnosis)*
Snellen/E-chart acuity measurements or visual field testing report

☐ **Invasive cancer:** *stage* __________ *grade* __________
Pathological report

☐ **Carcinoma in situ**
Pathological report

☐ **Coma**
Glasgow coma scale of 8 or less for at least 96 hours

☐ **Deafness** *(initial diagnosis)*
Permanent and irreversible hearing loss in both ears supported by audiometric testing

☐ **Heart attack**
EKG, imaging studies, stress echocardiogram, thallium scans, MUGA scans, and/or lab reports showing elevated cardiac enzymes or biochemical markers

☐ **Kidney (renal) failure**
Chronic, irreversible failure of both kidneys to function and renal dialysis

☐ **Major organ failure**
Irreversible failure of the blood marrow, heart, lung, liver or pancreas

☐ **Multiple sclerosis**
Clinical evidence including but not limited to MRI, cerebrospinal fluid analysis or visual evoked potentialsor pancreas

☐ **Occupational HIV**
FDA-approved ELISA and positive supplement tests within 14 days and 26 weeks

☐ **Parkinson (stage IV)**
Documented neurological and clinical diagnosis

☐ **Paralysis**
Documented clinical diagnosis, EMG, nerve conduction velocity tests

☐ **Severe burn**
Documented clinical diagnosis of third-degree burns requiring debridement/grafting

☐ **Stroke**
Documented clinical diagnosis, CT scan, MRI and cerebral angiography

☐ **Cerebral palsy (children only)**
Documented clinical diagnosis

☐ **Cleft Lip/palate (children only)**
Documented clinical diagnosis

☐ **Cystic fibrosis (children only)**
Positive sweat test with evidence of chronic lung disease and pancreatic insufficiency

☐ **Down syndrome (children only)**
Karyotype testing showing a full or partial extra copy of chromosome 21

☐ **Spina bifida (children only)**
Documented clinical diagnosis

When did symptoms first appear?	Date you were first consulted for this condition:	Date of definitive diagnosis:
Has patient ever had same or similar condition? ☐ Yes ☐ No	*If yes, indicate when and describe:*	
Name of referring physician, if any:	Referring physician phone number:	Referring physician address (Street, City, State, Zip Code):
Describe other diseases or infirmities affecting present condition:		

Report of Services

Date of Service	Place of Service*	Description of surgical and/or medical service provided	CPT Code

*IH – inpatient hospital, OH – outpatient hospital, OA – outpatient ambulatory surgical facility, DO – doctor's office, OL – other location

Was patient hospital confined? ☐ Yes ☐ No	Hospital name:
Admission date:	Discharge date:
Attending physician name *(Last, First, Middle Initial)*:	Phone number:
Address (Street, City, State, Zip Code):	

The above statements are true to the best of my knowledge and belief, and I have read the applicable fraud warning notice on page 2

Signature	Date