MEDMUTUAL PROTECT®
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY
P.O. Box 14327 Reading, PA 19612
Telephone: 855.521.9345 Fax: 610.374.6986
Portal: https://medmutualprotect.loomislive.com

CRITICAL ILLNESS CLAIM FORM

Instructions to File a Claim:

- Claims must be submitted within one (1) 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.

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)	

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?

Cancer / Cancer In Situ / Skin 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 14 days? ☐ Yes ☐ No	Has the patient required intubation for respiratory assistance? ☐ Yes ☐ No

(Please attach copies of medical records documenting diagnosis.)

Coronary Artery Bypass Surgery / Angioplasty

Type of Procedure: ☐ Bypass ☐ Angioplasty *(Please provide operative report.)*	Date of Procedure: ______________________

End-Stage Renal (Kidney) Failure

Has there been chronic, irreversible failure of the function of both kidneys? ☐ Yes ☐ No	Has the patient undergone peritoneal dialysis on at least a weekly basis? ☐ 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.)

Major Human Organ Transplant

Has the patient been the recipient of a human-to-human transplant? ☐ Yes ☐ No	Type of transplant: ☐ Kidney ☐ Heart ☐ Heart-Lung ☐ Lung ☐ Liver ☐ Pancreas	Date of Procedure: ________________ *(Please provide operative report.)*

Major Third-Degree Burns

Third degree burns? ☐ Yes ☐ No	Percent of total body surface affected: ________________

(Please attach copies of medical records documenting diagnosis.)

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Occupational HIV	
Has the patient undergone a blood test within 5 days of the accident that indicates the absence of HIV or antibodies of the HIV Virus? ☐ Yes ☐ No	Has the patient undergone further blood tests within 12 months that indicates the presence of HIV or antibodies of the HIV Virus? ☐ Yes ☐ No
(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.)	
Paralysis / Loss of Sight, Speech or Hearing /	
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