Chubb Workplace Benefits
A business unit of Combined Insurance Company of America, a Chubb Company
Claim Department
P.O. Box 6700 Scranton, PA 18505-0700
Telephone 1-888-499-0430 • Fax 312-351-6930

CHUBB

LBT Accelerated Benefit Claim Form

Employer's/Business Entity's Statement

Name of Employee/Insured Person | Social Security No. (Last 4 digits) | Date of Birth Mo / Day / Year

Phone No. ( ) | Group No. | Occupation

Employee's/Insured Person's Street Address | City | State | Zip

Employer/Business Entity | Employer/Business Entity Phone No. ( ) | Duties

Employer's/Business Entity's Street Address | City | State | Zip

Signed in (City/State) _____ This _____ Day of (Month/Year) _____

Name of Company | Signature | Official Position

Claimant's Statement

☐ Home Health ☐ Adult Day Care ☐ Assisted Living ☐ Other _____

Policyholder | Policyholder's Social Security No. (Last 4 digits) | Policy No.

Patient's Name | Patient's Social Security No. (Last 4 digits) | Phone No. ( )

Street Address | City | State | Zip

Type of Residence:
☐ Home ☐ Apartment ☐ Retirement Community ☐ Other _____

Describe condition for which claim is being made

Name of Attending Physician | Phone No. ( )

Street Address | City | State | Zip

Name of Hospital | Date Admitted / / | Date Discharged / /

Street Address | City | State | Zip

Name, address and telephone number of person assisting with claim (if any)
Name | Relationship | Phone No. ( )

Street Address | City | State | Zip

Attach a copy of Legal Instrument. Check One: ☐ Power of Attorney ☐ Guardianship

Patient or Personal Representative's Signature _____ Date _____

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Assessment Form To be completed by Case Manager, Social Security Worker, Registered Nurse or Physician

Patient Name

Date of Birth
Mo / Day / Year

Diagnosis and Concurrent Condition

Date symptom first appeared
Mo / Day / Year

Date patient first consulted you for this condition
Mo / Day / Year

Has patient ever had same condition? ☐ YES ☐ NO

Is patient still under your care for this condition? ☐ YES ☐ NO

Was patient hospitalized? ☐ YES ☐ NO

Was patient in a nursing home facility? ☐ YES ☐ NO

From: _____ To: _____

Period authorization for this condition

Medicare Coverage ☐ YES ☐ NO

From: _____ To: _____

The above listed patient requires care to perform the following Activities of Daily Living or Instrumental Activities of Daily Living.
I= Independent S=Stand-by Assistance at Arm's Length O=Needs Hands-On to Perform

ADL	I	S	O	**IADL**	I	S	O
Bathing				Medicine Admin			
Dressing				Personal Financial			
Toileting				Prepare/Cook Meals			
Continence				Use Telephone			
Mobility				Housework			
Transfers				Laundry			
Feeding/Eating							

Cognitive Impairment: ☐ YES ☐ NO (If "Yes", attached Clinical Test/Documentation)

I hereby certify that the above listed patient will be chronically ill for a period of 90 days or more: ☐ YES ☐ NO

Patient requires: ☐ Home Health Care ☐ Adult Day Care ☐ Hospice Program ☐ Respite Care ☐ Assisted Living Facility

Recommended services: ☐ Nurse ☐ Therapist ☐ Homemaker ☐ Companion ☐ Other

Total number of days per week: Number of hours per day: Where is care being provided? ☐ Home ☐ Apartment ☐ Retirement Community ☐ Facility ☐ Other

Name of Provider Tax ID/Social Security No. Phone No. ( )

Street Address City State Zip

Type of License: ☐ Health Care Agency Care ☐ Adult Day Care ☐ Hospice Program ☐ Other

Print Name Degree Phone No. ( )

Street Address City State Zip

Signature _____ Date _____

Attach the following documents:

1) Plan of Care
2) Itemized Billing Statement
3) Explanation of Medicare Benefit Statements (if Medicare coverage on these services)

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Fraud Notifications

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who 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: Any 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: 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 information to obtain or amend insurance coverage or to make a 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.

DELAWARE: 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: Any person who knowingly and with the 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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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 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..

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

MAINE, TENNESSEE, WASHINGTON or WEST VIRGINIA: 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.

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.

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 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 N.H. Rev. Stat. Ann. § 638:20.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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FRAUD NOTIFICATIONS CONTINUED

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.

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 the 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.

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.

RHODE ISLAND: 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.

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.

VIRGINIA: Any person who, with the intent to defraud or knowingly that he/she is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

FOR RESIDENTS OF ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Claimant's Signature: _____ Date: _____

CHUBB

Authorization for the Release of Health Information

Combined Insurance Company of America, a Chubb company, is identified as "the Company" in this authorization document.

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. Person(s) or group(s) of persons authorized to use and/or disclose the Information: Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. Description of the information that may be used or disclosed: This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or Information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
4. The information will be used or disclosed only for the following purpose(s): The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.

I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosers of my health Information for purposes of treatment, payment or health care operations.

This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy. A copy of this authorization will be considered as valid as the original.

I acknowledge that I have received a copy of this authorization.

Patient Insured's Name/Signature | Date

Patient Insured's SSN | Patient Insured's Date of Birth | Patient Insured's Phone No.

Patient Insured's Address

Personal Representative's (if any) Name/Signature | Personal Representative's Phone No.

Personal Representative's (if any) Address

Description of Personal Representative's Authority or Relationship to Patient Insured

Policy or Contract Number

Claimants should retain a copy of this signed document for their records.