Welcome to

ADVANTAGE GROUP

ATTENTION:

Completed claim forms should be emailed, faxed, or mailed to:

policySVC@advantagegroupga.com
fax (715) 241-5375
510 Alderson St
Schofield, WI 54476

Please include the following:

- Claimant Statement
- Attending Physician's Statement
- Personal Health Information Release Form
- Clinical Records, Pathology Reports, Operative Reports, Test Results, medical documentation to support the claimed critical illness.

Need Assistance?

Contact our Claims Department:

policySVC@advantagegroupga.com
(844) 441-5372 ext 100

Office Hours: Monday through Thursday 8-4, Friday 8-12

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

CRITICAL ILLNESS CLAIM FORM

Mail, email or fax your claim to us at:
300 SW Adams St, Peoria IL 61634
claims@IllinoisMutual.com
Fax (309) 673-8137

TO BE COMPLETED BY INSURED

POLICYOWNER'S INFORMATION

Policy Number	Claim Number	Date

1a.	PATIENT'S NAME (First name, middle initial, last name)	1b.	DATE OF BIRTH
2.	ADDRESS STREET OR PO BOX	CITY	STATE ZIP
3.	CELL PH. (_____) _____	4.	EMAIL _____
5.	HOME PH. (_____) _____	6.	EMPLOYER'S PH. (_____) _____

CLAIMANT'S INFORMATION

7a.	NAME (First name, middle initial, last name)	7b.	DATE OF BIRTH	7c.	SOCIAL SECURITY NUMBER

8.	GENDER ☐ Male ☐ Female	9.	MARITAL STATUS ☐ Single ☐ Married	10.	RELATIONSHIP TO POLICYOWNER: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic Partner/Civil Union ☐ Check if dependent is full-time student

CRITICAL ILLNESS INFORMATION Specify which type of condition you are claiming

11.
- ☐ Burns
- ☐ Coma
- ☐ Coronary Angioplasty
- ☐ Coronary By-Pass Surgery
- ☐ End-Stage Renal Disease
- ☐ Heart Attack
- ☐ Heart Transplant
- ☐ Loss of Hearing
- ☐ Loss of Sight
- ☐ Loss of Speech
- ☐ Major Organ Transplant
- ☐ Paralysis
- ☐ Stroke
- ☐ Cancer

12. **Dependent Child Critical Illnesses:**
- ☐ Cerebral Palsy
- ☐ Congenital Heart Disease
- ☐ Cystic Fibrosis
- ☐ Muscular Dystrophy
- ☐ Pyloric Stenosis
- ☐ Spina Bifida
- ☐ Type One Diabetes
- ☐ Down Syndrome

MEDICAL INFORMATION

13.	ATTENDING PHYSICIAN'S NAME (First name, middle initial, last name)
14.	ADDRESS STREET OR PO BOX CITY STATE ZIP

15.

a. Diagnosis _____

b. Date Symptoms first appeared _____ c. Date first diagnosed _____

d. Did you ever receive treatment for the same or similar condition? ☐ Yes ☐ No

If yes, when? _____ Name/Address of physician _____

_____

e. Were you ever hospitalized for this condition? ☐ Yes ☐ No

If yes, indicate Name/Address of hospital _____

Date Seen/Admitted _____ Date Discharged _____

Medical Carrier – Name/Address/Policy No. _____

_____

Notice: Your signature and date on this form indicates that you acknowledge the fraud warning applicable in your state as indicated on the attached page.

_____ _____
CLAIMANT'S SIGNATURE (if minor, parent must sign) RELATIONSHIP, IF NOT POLICYOWNER

_____
DATE

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

CRITICAL ILLNESS ATTENDING PHYSICIAN'S STATEMENT

Mail, email or fax your claim to us at:
300 SW Adams St, Peoria IL 61634
claims@IllinoisMutual.com
Fax (309) 673-8137

TO BE COMPLETED BY INSURED

Policy Number		Claim Number	
1a.	PATIENT'S NAME (First name, middle initial, last name)	1b.	DATE OF BIRTH
2.	ADDRESS STREET OR PO BOX	CITY	STATE ZIP
3.	PATIENT'S SIGNATURE (If minor parent must sign): I authorize the release of any medical information necessary to process my claim. SIGNATURE _____ DATE _____		

TO BE COMPLETED BY ATTENDING PHYSICIAN

CRITICAL ILLNESS INFORMATION

Specify which condition your patient has been diagnosed with, and provide the supporting documentation as outlined on page 2.

4.	☐ Burns ☐ Coma ☐ Coronary Angioplasty ☐ Coronary By-Pass Surgery ☐ End-Stage Renal Disease ☐ Heart Attack ☐ Heart Transplant	☐ Loss of Hearing ☐ Loss of Sight ☐ Loss of Speech ☐ Major Organ Transplant ☐ Paralysis ☐ Stroke ☐ Cancer	5.	**Dependent Child Critical Illnesses:** ☐ Cerebral Palsy ☐ Congenital Heart Disease ☐ Cystic Fibrosis ☐ Muscular Dystrophy ☐ Pyloric Stenosis ☐ Spina Bifida ☐ Type One Diabetes ☐ Down Syndrome	
6.	DIAGNOSIS		7.	DATE OF DIAGNOSIS ☐ ☐	8. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:
9.	HAS THE PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF YES, INDICATE FIRST TREATMENT DATES:		10.	NAME AND ADDRESS OF REFERRING PHYSICIAN	

PHYSICIAN'S INFORMATION AND SIGNATURE

11.	PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT): _____
12.	MEDICAL SPECIALTY: _____ PHONE NUMBER (_____) _____
13.	PHYSICIAN'S ID NUMBER: _____ FAX NUMBER (_____) _____
	Notice: Your signature and date on this form indicates that you acknowledge the fraud warning applicable in your state as indicated on the attached page.
14.	PHYSICIAN'S SIGNATURE: _____ DATE: _____

Please provide the following medical documentation to support the claimed critical illness such as copies of clinical records, pathology reports, operative reports and test results.

Condition	Documentation
Burns	Clinical records to include the severity of burn and % of surface area of the body
Coma	Clinical records to include the Glasgow Coma Scale score
Coronary Angioplasty, By-Pass Surgery	Clinical records to include surgical and operative reports
Heart Attack	Clinical records from a board certified cardiologist to include EKG and cardiac markers
Heart or Major Organ Transplant:	Clinical records to include proof of registration and acceptance to the United Network for Organ Sharing (UNOS)
End-Stage Renal Disease	Clinical records from kidney specialist and dialysis records
Loss of Hearing	Clinical records to include audiometric testing
Loss of Sight	Clinical records to include visual acuity testing or visual field restrictions
Loss of Speech	Clinical records
Paralysis	Clinical records
Stroke	Clinical records to include neuroimaging studies as well as new documented neurological deficits 30 days post event
Cancer	Clinical records to include pathology and surgical reports as well as the TMN Stage

Dependent Child Critical Illnesses	Documentation
Congenital Heart Disease	Clinical records from a pediatric cardiologist to include cardiac imaging
Muscular Dystrophy	Clinical records to include electromyography results and muscle biopsy
Type One Diabetes	Clinical records from a board-certified endocrinologist to include blood tests and confirmation of the cause of low insulin production
Cerebral Palsy	Clinical records
Cystic Fibrosis	Clinical records
Down Syndrome	Clinical records
Pyloric Stenosis	Clinical records
Spina Bifida	Clinical records

ILLINOIS MUTUAL®
Life Insurance Company

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

This Authorization is intended to comply with the HIPAA Privacy Rule (45 C.F.R. Part 164, Subpart E).

Proposed Insured or Claimant: _____ Date of Birth: _____

Address: _____ Policy/Claim Number: _____

PURPOSE

Providing this Authorization enables Illinois Mutual Life Insurance Company and its agents, employees, and representatives (collectively, "Illinois Mutual") to underwrite your application and determine your eligibility for coverage, obtain reinsurance, administer coverage issued to or claims made by you, and conduct other legally permitted activities relating to the coverage for which you have applied or that is issued to you. Providing this Authorization is voluntary, but if you decline to provide this Authorization, Illinois Mutual may deny your application for coverage or your claim for benefits.

AUTHORIZATION

I authorize and request:
any health plan, physician, other health care professional or practitioner, clinic, hospital, psychiatric facility or mental health institution, other health care facility or health care provider, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsurance company, viatical broker, provider or company, healthcare clearinghouse, ambulance or other healthcare transport service, MIB Inc., government agency, consumer reporting agency, insurance support organization, third party administrator, and any other organization, institution, or person that has screening, diagnosis, treatment, prescription, or other health or health payment information about me (each, an "Information Source"), to release and disclose to Illinois Mutual, all such screening, diagnosis, treatment, prescription, or other health or health payment information about me, including (a) my entire medical and health care claims records; and (b) any information relating to mental health (other than psychotherapy notes), drug, alcohol or other substance misuse, Human Immunodeficiency Virus ("HIV") infection and other sexually transmitted diseases, and dental and vision health (collectively, my "Personal Health Information"). My Personal Health Information includes any protected health information subject to the HIPAA Privacy Rule.

This Authorization overrides any agreement I may have made with any Information Source to restrict use or disclosure of my Personal Health Information. I instruct Information Sources to release and disclose my Personal Health Information to Illinois Mutual, or its reinsurers, without restriction.

I authorize Illinois Mutual to use and to re-disclose my Personal Health Information for the purpose stated above, including to make a brief report to MIB Inc. and to other parties providing services to Illinois Mutual who may be involved with my claim. I understand that Illinois Mutual will not otherwise use or re-disclose my Personal Health Information, except as further authorized by me or as permitted or required by law. I further understand that once my Personal Health Information is redisclosed by Illinois Mutual, it may no longer be protected by Federal or other laws.

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

EXPIRATION AND REVOCATION

Unless I earlier revoke this Authorization by written notice to Illinois Mutual, this Authorization will expire 24 months following the date I enter below (except that it shall remain in force for the duration of the policy in Minnesota; 30 months in Arizona, California, Connecticut, Delaware, Georgia, Illinois, Maine, Massachusetts, Nevada, New Jersey, North Carolina, Ohio and Virginia; 1 year for mental health records in Maine; 1 year for substance abuse records in Alabama; 90 days for Iowa HIV infection and sexually transmitted diseases records; and 180 days for Arizona HIV infection and sexually transmitted diseases records). I understand I may revoke this Authorization at any time by written notice of revocation to Compliance Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, Illinois 61634. I understand that a revocation is not effective to the extent that Illinois Mutual or any Information Source has relied on this Authorization before receiving notice of my revocation, or to the extent Illinois Mutual has a legal right to contest a claim under an insurance policy or to contest the policy itself.

ACKNOWLEDGEMENT AND SIGNATURE

I have read this Authorization. I understand that, upon request of Illinois Mutual, I am entitled to a copy of this Authorization bearing my signature or the signature of my personal representative below. I agree that a photocopy or facsimile of this signed Authorization is as valid as the original.

_____ _____

Date

Signature of Proposed Insured or Claimant

_____

Printed Name of Proposed Insured or Claimant

_____

Signature of Personal Representative authorized by law to give this Authorization

_____

Personal Representative's authority or relationship to Proposed Insured or Claimant

_____

Practitioner or Facility (Home Office Use Only)

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

GENERAL FRAUD STATEMENT: 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.

For residents of 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 restitution fines or confinement in prison, or any combination thereof.

For residents of 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.

For residents of 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.

For residents of Arkansas, Louisiana, Rhode Island, and 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.

For residents of 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.

For residents of 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.**

For residents of 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.

For residents of 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.

For residents of 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.

For residents of Georgia: 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, may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of 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.

For residents of Kansas: 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, may be guilty of insurance fraud as determined by a court of law.

For residents of 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.

For residents of Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of 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.

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

For residents of 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.

For residents of New York: 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 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.

For residents of 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.

For residents of 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.

For residents of Oregon: 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, may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of Tennessee, Virginia, and 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.

For residents of 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.

Underwritten by: Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 309.674.8255