MEMBER BENEFITS
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Working to Benefit You

GROUP CATASTROPHE MAJOR MEDICAL PLAN

Sponsored by NYSUT Member Benefits Catastrophe Major Medical (CMM) Insurance Trust

CRITICAL ILLNESS CLAIM FORM

PLEASE NOTE

USE THIS CLAIM FORM IF THE ORIGINAL DIAGNOSIS OCCURED PRIOR TO JANUARY 1, 2018

- For an original diagnosis occurring prior to January 1, 2014, the CMM Plan Certificate of Insurance (Policy # E-610,219) applies.
- For an original diagnosis occurring between January 1, 2014 and December 31, 2017, the CMM Plan Document (Policy # CMMI-002) applies.
- **DO NOT USE THIS FORM** for original diagnosis dates on or after January 1, 2018 regarding CMM Policy # CMMI-004; rather send your claim to HealthSmart (healthsmart.com/nysut or 844-552-7805).

CLAIM FORM INSTRUCTIONS

1. Complete the Insured/Claimant's Information section.
2. Read the Fraud Statement section and sign in the space provided.
3. Review and sign the HIPAA Authorization Form. The Authorization will help us obtain any additional information needed to process your claim. Failure to sign the Authorization will delay the processing of your claim.
4. Have your attending physician complete the Attending Physician's Statement section of this form for the specific critical illness for which the claim is being made. If you are filing for cancer under the critical illness benefit, please attach the pathology report that confirms the diagnosis.
5. Mail your claims to:

   Association Member Benefits Advisors
   PO Box 10362
   Des Moines, IA 50306-0362
   Questions: 888-386-9788

INSURED/CLAIMANT INFORMATION			
Name of Insured	Policy # **CMMI-002** **E-610,219**	NYSUT ID # (seven-digit)	Date of Birth
Insured's Address, Street & No, City State Zip			Phone
Patient's Name		Relationship to Insured	Patient's Date of Birth
What is the specific Critical Illness for which the claim is being made	When was the Critical Illness first diagnosed	Have you ever had the same or similar condition: ☐ YES ☐ NO	
List the name, address, and telephone number for all attending physicians for the Critical Illness (Please attach a separate list if additional space is needed).			
If the Critical Illness required hospitalization, provide the name and address of the treating facility (Please attach a separate list if additional space is needed).			
IMPORTANT NOTICE: It is unlawful for any person to knowingly, and with the intent to defraud, present, or cause to be presented, or prepare with the knowledge and belief that it will be presented to a self-insurer, a claim for payment, containing any materially false information concerning any material fact related to such claim, or to conceal, for the purpose of misleading, information concerning any material fact related to such claim (collectively, "Unlawful Acts"). Such Unlawful Acts may also lead to a denial of benefits from this Plan.			
Participant's Signature:	Date:	Claimant's Signature:	Date:

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	DATE OF BIRTH	DATE OF DEATH (IF APPLICABLE)

WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? ☐ YES, WHEN _____ ☐ NO	DIAGNOSIS (INCLUDING COMPLICATIONS)

CANCER

DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER WAS DIAGNOSED)	WAS THE CANCER/CARCINOMA IN SITU ☐ PATHOLOGICALLY DIAGNOSED OR ☐ CLINICALLY

IF THE CANCER WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

MYOCARDIAL INFARCTION (HEART ATTACK)

DOES THE PATIENTS CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

1.	ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKG'S AND REPORTS.	☐ YES ☐ NO
2.	WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHYSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT.	☐ YES ☐ NO
3.	DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.	☐ YES ☐ NO
4.	DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?	☐ YES ☐ NO

DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)

CORONARY ARTERY BYPASS SURGERY

DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.	☐ YES	☐ NO

WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

MAJOR ORGAN TRANSPLANT

DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, KIDNEY, LUNG, LIVER OR BONE MARROW? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.	☐ YES	☐ NO

WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

STROKE

DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTERBROBASILAR ISCHEMIA.	☐ YES	☐ NO
DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN REPORT OR MAGNETIC RESONANCE IMAGING (MRI) REPORT.	☐ YES	☐ NO

DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES)?

QUADRIPLEGIA

DOES THE PATIENT HAVE COMPLETE AND PERMANENT LOSS OF THE USE OF ALL FOUR LIMBS THROUGH PARALYSIS FOR A CONTINUOUS PERIOD OF 180 DAYS OR MORE?	☐ YES	☐ NO

WHAT IS THE CAUSE FOR THE PATIENT'S QUADRIPLEGIA?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

TERMINAL ILLNESS

DOES THE PATIENT HAVE A MEDICAL CONDITION, WHICH IS EXPECTED TO RESULT IN THE PATIENT'S DEATH WITHIN 12 MONTHS AND FROM WHICH THE PATIENT IS NOT EXPECTED TO RECOVER?	☐ YES	☐ NO

WHAT IS THE CAUSE FOR THE PATIENT'S TERMINAL ILLNESS?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?

ATTENDING PHYSICIAN'S SIGNATURE

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

NAME (ATTENDING PHYSICIAN) PLEASE PRINT	DEGREE	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	

MEMBER BENEFITS
nysut
Working to Benefit You

HIPAA Authorization Section
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	NYSUT Member ID # (seven-digit)

I hereby authorize all of the people and organizations listed below to give NYSUT Member Benefits Catastrophe Major Medical Insurance Trust ("Trust"), and their authorized representatives, including its administrator, Association Member Benefits Advisors (AMBA), as well as other agents and insurance support organizations, (collectively, the "Recipients"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company;
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipients to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Recipients listed above are subject to federal privacy regulations. I understand that information released to the Recipients will be used and disclosed as described in the Trust's HIPAA Privacy Notice, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipients to contest a claim under the policy or to contest the policy itself, by sending a written request to: Association Member Benefits Advisors, PO Box 10362, Des Moines, IA 50306-0362. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipients for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Recipients may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Claimant or Claimant's Personal Representative | Date

_____

Description of Authority of Personal Representative (if applicable)