

Monumental Life Insurance Company

National Employee Benefit Companies, Inc.

TRICARE CLAIM STATEMENT

INSTRUCTIONS: HOW TO SUBMIT A TRICARE CLAIM:

1. The form must be completed in full by Member and;
2. The reverse side must be completed by the claimant or claim delay may result.
3. Send the appropriate medical bills, hospital bills, and all Explanation of Benefit worksheets from TRICARE to:

Claims Department, WEB-TPA, P.O. Box 1868, Grapevine, TX 76099-1868

4. TRICARE Prime claimants must submit a receipt from the provider of care showing the co-payment amount.

Name Of Member:	Certificate Number:	Date of Birth:
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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____
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Address: (Street, City, State & Zip Code)

Name of Patient:	Date of Birth:	Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter
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Nature of Accident or Illness – Describe:

Have you claimed benefits for this condition previously?
 Yes No If yes, when? _____

Provide Name and Address of any Physician Contacted for this Condition:

Name: _____

Address: _____

Name: _____

Address: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of eligible benefits under my policy in connection with this injury or illness directly to (enter name of provider of care: hospital, doctor, etc.)

X _____

Signature

Date

FRAUD WARNING NOTICES

Your state may require the following notice: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, or misleading information is subject to criminal and civil penalties and may be guilty of a felony.

Alaska, New Hampshire: 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.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, 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.

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.

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 any 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.

Maine, Virginia, Tennessee, 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.

Delaware, Idaho, Indiana: 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.

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.

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.

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.

Kentucky, 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.

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 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 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.

Oregon: 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 may be subject to prosecution for insurance fraud.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient identified below. I understand that information used or disclosed pursuant to this authorization could be subject to **re-disclosure** by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. You are hereby authorized to give to the Company specified below, or its representatives, copies of any records or data which have to do with the **physical or mental health including drug, alcohol, psychiatric, HIV infection or AIDS related treatment**. A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Date of Death: _____

Address: _____

Information to be disclosed to: **Monumental Life Insurance Company**
Or their Representative (EMSI, ScanTech Solutions and/or LabONE)

Disclose the complete records including the following information for treatment dates: _____ to _____:

- | | | | |
|---|-------------------------------------|--|--|
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Consults | <input type="checkbox"/> Office Records | <input type="checkbox"/> Death Summary |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-Ray | <input type="checkbox"/> Emergency Reports | <input type="checkbox"/> Toxicology |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Autopsy |
| <input type="checkbox"/> Outpatient Reports | <input type="checkbox"/> Pathology | <input type="checkbox"/> EMS Report | <input type="checkbox"/> Medications |

The above information is disclosed for the purpose of processing an insurance claim.

I understand I may **revoke this authorization** at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization **expires 2 years from the date signed**; unless otherwise noted here: _____.

IMPORTANT – If patient is deceased, please INITIAL one of the statements below:

_____ I am the Administrator/Executor for the deceased & Letters of Testamentary (or comparable documents) are attached.
Initial here

_____ There is no court appointed Administrator/Executor and I am the next of kin.
Initial here

I understand that I am not required to sign this authorization. The above named health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

I also authorize any doctor, hospital, or other medical or medically related facility, treatment center, recovery center, insurance company, consumer reporting agency, employer, Social Security Administration or any other organization or person having any knowledge of the patient named above, including financial institutions, and law enforcement agencies to give Monumental Life Insurance Company or its authorized representative any information needed to determine policy claim benefits. This may include (but is not limited to) information regarding HIV antibody testing, Acquired Immune Deficiency Syndrome or related complexes, driving records, financial records, police or accident reports, mental illness and use of alcohol or drugs.

Signature of Legal Representative

Date

Printed name of Legal Representative

Relationship or authority to act for Patient

Witness

Date

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS