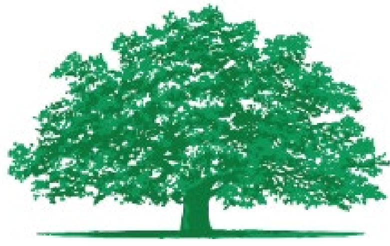

Group Critical Illness Claim Form

Mail to: Canopy Insurance Claims Processing, PO Box 3187, Tuscaloosa, AL 35403
Email to: Claims@CanopyInsuranceCorp.com
Fax to: 205-409-2527

Please submit this form via mail, email, or fax. Be sure to include any additional pages used to respond to the questions below along with any documentation from your healthcare provider to support this claim. If you have additional documentation that relates to the diagnosis other than the documents defined below, please submit them for review of additional benefits. If you have any questions or would like to check the status of your claim, please call our **Customer Service Department at 205-451-0444**.
Note: Some of the services listed may not be covered by your policy. Refer to your certificate of coverage for benefits available under your plan.

GROUP INFORMATION

Group Name: ______________________ **Group Number:** ______________

Group Contact Information (This is generally someone in Human Resources or Administration)

Contact Name: ______________ **Email:** ______________ **Phone Number:** ______________

PRIMARY INSURED INFORMATION

Full Name: ______________ **DOB:** ______________ **SSN:** ______________ **Member ID:** ______________

Mailing Address: ____
Street *City* *State* *Zip*

Phone Number: ______________ **Email:** ______________

CLAIMANT INFORMATION

Full Name: ______________ **DOB:** ______________ **Gender:** ______________ **Relationship:** ______________

Phone Number: ______________ **Email:** ______________ **Date of Death (if applicable):** ______________

CLAIM INFORMATION

PLEASE CHECK CONDITION FOR WHICH YOU ARE CLAIMING A BENEFIT.
Attach all relevant medical records, including physician's progress notes, test results, admission/discharge summaries, and operative report(s).

- ☐ Cancer
- ☐ Coronary Artery Bypass Surgery
- ☐ Heart Attack
- ☐ Major Organ Transplant
- ☐ Stroke
- ☐ Addison's Disease
- ☐ Alzheimer's
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Angioplasty/Stent
- ☐ Benign Brain Tumor
- ☐ Coma
- ☐ Carcinoma in Situ (not including Skin Cancer)
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ End-stage Renal Failure
- ☐ Huntington's Disease
- ☐ Loss of Hearing
- ☐ Loss of Speech
- ☐ Multiple Sclerosis (MS)
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Paralysis
- ☐ Skin Cancer

Date Symptoms Appeared: ______________ **Has Claimant had same/similar condition(s) in the past?** ☐ No ☐ Yes*
*If yes, please provide date(s) of prior treatment, along with physician names, addresses, phone, & fax.

HOSPITAL INFORMATION (if applicable) - Attach a separate piece of paper if additional space if needed.

Name of Hospital: ______________ **Date Admitted:** ______________ **Date Discharged:** ______________

Name of Hospital: ______________ **Date Admitted:** ______________ **Date Discharged:** ______________

FAMILY PHYSICIAN INFORMATION - Attach a separate piece of paper if additional space if needed.

Practice Name: ______________ **Provider Name:** ______________

Address: ____
Street *City* *State* *Zip*

Phone Number: ______________ **Fax:** ______________

PHYSICIANS AND HOSPITALS THAT TREATED THE CLAIMANT FOR ILLNESS/INJURY - Attach a separate piece of paper if additional space if needed.

Name of Hospital/Practice: ______________ **Provider Name:** ______________

Mailing Address: ____
Street *City* *State* *Zip*

Phone Number: ______________ **Fax:** ______________

AUTHORIZATION

I authorize any third party to release any and all medical and non-medical information about me to Canopy Insurance Corporation or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I understand that information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Canopy will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I may request and receive a copy of this authorization, and agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim.

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.

"Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose and will not be retained in any record other than that pertaining to the claim."

____ ______________
Signature of Primary Insured or Power of Attorney (attach Power of Attorney, if applicable) Date

____ ______________
Signature of Claimant (if different than Primary Insured) or Power of Attorney (attach Power of Attorney, if applicable) Date