BANKERS
LIFE AND CASUALTY COMPANY

Filing a first time Long-Term Care (LTC) Insurance Claim with Bankers Life and Casualty Company

The purpose of this instructional document is to assist you through the claim filing process. There is important information we must receive from multiple parties in order to appropriately evaluate each claim. Required claim material must be received in order for payment to be considered. Bankers provides resources to assist you throughout the process.

LTC Claim Checklist

Filing a claim can be done in 4 steps! Please refer to the detailed information below.

- ☐ 1: Call the Intake Team
- ☐ 2: Fill out the claim form
- ☐ 3: Provide authorized representatives
- ☐ 4: Submit documentation

During the initial claim filing process, we may ask for additional information from you and/or your provider(s) to learn more about your condition and care needs.

Step 1: Call the Intake Team before you file a claim

Before you file a claim, please contact one of our Intake Specialists. They will work with you one-on-one to answer your questions, walk you through your policy benefits and assist you with the claim filing process. You can reach an Intake Specialist at **1(800) 621-3724** between the hours of 8:00 AM – 4:30 PM Central Time, Monday through Friday. Intake Specialists can assist with such questions as:

- Who are the qualified Providers in my area?
- What types of services and expenses does my specific policy actually cover? What are my dollar limits?
- What factors are considered to determine if I qualify to receive policy benefits?
- What is an Elimination Period? Must I satisfy an Elimination Period before I file a long-term care claim?
- What information may be requested during the claim process?
- How quickly can I expect a decision on my claim?
- What do I need to submit to receive reimbursement?

Step 2: Fill out the claim form

Once your care begins, you will need to complete a claim form. Please keep the following items in mind when filing an LTC claim:

- Provide as much detail as possible to each of the questions, including you and your providers' current addresses and telephone numbers. Providing incomplete information may lengthen the claim processing time.
- Feel free to attach additional pages if you need more room to respond to any question.
- Sign the enclosed Authorization for Claims Processing Purposes form included with the claim packet.

Step 3: Provide authorized representatives

If the insured will not be handling his/her claim personally, Bankers will need one of the following so an authorized representative can manage the claim on the policyholder's behalf:

1. A signed Third Party Authorization Form
2. A copy of Healthcare or Durable Power of Attorney document

Step 4: Submit documentation

Mail the completed claim form and all available claim documentation to:
Bankers Life and Casualty Company
PO Box 1902
Carmel, IN 46082-1902

Or send via fax at **(312) 396-5952**.

You or your designated representative will be contacted within ten to fifteen business days of receipt of your documents to advise that we have received your request for benefits and inform you if additional information is needed.

What to expect after submitting your claim

For an accurate and timely review of your claim, we will need to gather specific information. Following is a list of items we may request from your care Provider. Your help in gathering documentation is greatly appreciated as it will decrease the likelihood of delays or closure of your claim due to missing information. Referenced below are Provider types along with a list of specific items we may need to collect in addition to the claim form:

*If you are unsure of what type of Provider is covered by your policy or need assistance in locating an eligible provider in your area, please reach out to our Intake Team for assistance at **1(800) 621-3724**.*

From a Nursing Home

- ☐ Minimum Data Set (MDS): This information is collected by the nursing home staff in order to assess (measure) the physical, psychological, and social functioning characteristics of the resident.
- ☐ Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your policy.
- ☐ Facility License: A document showing that the Facility is licensed or certified.

From a Home Health Care Provider

- ☐ Plan of Care: A set of actions the care Provider will implement in order to resolve and/or support the diagnoses and/or care needs of the Policyholder.
- ☐ Daily Visit Notes: Documentation of the specific care provided during each visit by the caregiver. This documentation may also be referred to as: daily progress notes, nursing notes, staff notes or charts.
- ☐ Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your policy.

☐ Initial Provider Assessment: A written summary that provides a general description of the Policyholder (physical assessment, height, weight, age, etc.) and a description of their primary medical history.

☐ Provider qualifications including licensing for Agency, Aide, Caregiver, etc., as well as certification, and/or individual training or experience, if applicable per your policy.

From an Assisted Living Facility

☐ Facility's Service Plan: A set of actions the care Provider will implement in order to resolve and/or support the diagnoses and/or care needs of the Policyholder.

☐ Medication List: A list of all the medications the Policyholder is taking and information on how they are to be administered.

☐ Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your policy.

☐ Facility License: A document showing that the Facility is licensed or certified.

From an Adult Day Care Provider

☐ Adult Day Care Plan of Care: A set of actions the care Provider will implement in order to resolve and/or support the diagnoses and/or care needs of the Policyholder.

☐ Itemized Bill(s): This document shows the charges (by reason) you have incurred during care. The charges need to be itemized in order for us to verify which expenses are covered by your policy.

☐ Facility License: A document showing that the Facility is licensed or certified.

Questions

If you do not see your provider type listed or have additional questions, please contact our Intake Team Monday through Friday between 8:00 AM – 4:30 PM Central Time at 1(800) 621-3724, or visit our website at www.bankers.com.

Notes

- If any testing such as Mini Mental State Exam (MMSE) or a neuropsychological evaluation has been completed, please include this information in your claim submission.
- For non-facility claims; a Benefit Eligibility Assessment (BEA) may be requested during our eligibility review. This is a visit by a qualified licensed healthcare practitioner from an independent agency (not affiliated with Bankers) who conducts an assessment with the Claimant in their place of residence. During the assessment, this individual will gather information about the functional abilities of the Insured. They will also administer a cognitive screening and discuss relevant medical history and current health conditions of the Insured.

Claims Authorization for Medical Information

Conforms to HIPAA Privacy Rule

1. My Information – the individual who is the subject of the information

Printed Name	Date of Birth	Soc. Sec. Number (Last 4 Digits)	Policy Number

Address	City	State	Zip

2. Disclosing Party – the party or parties authorized to release information about me

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration or governmental agency

3. Description of my information authorized for release

Any/all information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse

4. Purpose of Authorization – how my information will be used

To administer benefits under a policy or certificate of insurance

5. Duration of Authorization

Twenty-four (24) months from the date written below, unless I specify an earlier date here: _____

6. Receiving Parties – the parties authorized to receive information about me

- Bankers Life and Casualty Company, its agents, representatives and reinsurers
- Bankers Conseco Life Insurance Company*, its agents, representatives and reinsurers
  **domiciled and licensed in the State of New York*

7. Important information – review carefully before signing

- Refusing to sign this Authorization does not affect my ability to obtain medical treatment, but may prevent my insurance company from being able to determine if benefits are payable under the terms of my coverage.
- This Authorization may be revoked at any time unless it was already relied upon. Send a written revocation to: LTC Claims Administration P.O. Box 1902, Carmel, IN 46082-1902.
- The Receiving Parties named above are subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I have a right to a copy of this Authorization, and that a photocopy or facsimile is as valid as the original.
- California residents are entitled to a large print version of this form by calling 800-621-3724 to request form 18727-LARGE.

8. Approval – must be signed and dated by me or my Legal Representative* to be valid

Printed Name	Relationship to the insured
Signature	Date signed

Legal Representatives must provide documentation of legal authority

Voluntary Authorization to Disclose Information to Third Party

Pursuant to the HIPAA Privacy Rule
For use in conjunction with Long Term Care policies only

I. My Information – The individual whose information will be released

_____ _____ _____ _____
Printed Name | Date of Birth | Policy Number | Social Security Number

_____ _____ _____ _____
Address | City | State | Zip Code | Telephone

II. Disclosing Party – Organization authorized to release my information

Bankers Life and Casualty Company*, Bankers Conseco Life Insurance Company**, Washington National Insurance Company*
*not licensed in the State of New York
**domiciled in and licensed in the State of New York

III. Description of my information authorized for release

☐ All information pertaining to my insurance transactions, claims and coverage including health and financial information

☐ Only information pertaining to_____

IV. Purpose of release – Describing how my information will be used by the Receiving Party after it is released

At the request of the individual identified above.

V. Duration of authorization

This authorization will expire 24 months from the date written below, unless I specify an alternate expiration date here: _____

VI. Receiving Party – Individual(s) or organization(s) authorized by me to receive my information

Name: _____ Company Name (if applicable) _____

Address: _____ Telephone: _____

Name: _____ Company Name (if applicable) _____

Address: _____ Telephone: _____

VII. Approval – Signed and dated by me or my legal representative

- I understand that this authorization to release information to a third party is optional and I am not required under the terms of my policy to give such authorization.
- I understand that I can revoke this authorization at any time, except to the extent it has already been relied upon, by sending a written revocation to the address below.
- I understand that my treatment, payment and eligibility for benefits may not be conditioned on this authorization.
- I understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, it could be re-disclosed and no longer protected by federal health information privacy laws.
- I understand that I am entitled to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____
* Legal Representatives provide documentation of legal authority

VIII. RETURN SIGNED AND DATED FORM

Long Term Care Claims - P.O. Box 1902, Carmel IN 46082-1902
Phone: (800) 621-3724 Fax: (312) 396-5952

BANKERS
LIFE AND CASUALTY COMPANY

www.bankers.com

LONG-TERM CARE AND SHORT TERM CARE CLAIM FORM

POLICY NUMBER: _____ Date: _____

If you would like assistance in completing this claim form, please call 1-800-621-3724.

Please send completed claim form to:
Bankers Life and Casualty Company
PO Box 1902
Carmel IN 46082-1902

1. Claimant Name: _____ Date of Birth: ____ / _____ / ____

   Address: _____

   City: _____ State: _____ Zip: _____

   To make an address change, please fill out the Address Change Request Form attached to this form.

   Phone: (_____) _____ Sex: ☐ M ☐ F

2. Contact Person (if unable to reach) Name: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Phone: (_____) _____ Relationship: _____

3. Describe your limitations. Indicate the first day the limitations were present, if applicable, or provide an approximate time frame: _____

   _____

   _____

   _____

   _____

   _____

   _____

4. Cause or Condition which requires you to need Long-Term Care: ☐ Sickness ☐ Injury

   _____

   _____

   _____

   _____

   _____

   _____

   If limitations caused by an injury, when, where, and how did it happen? _____

   _____

5. Are you currently, or have you been, hospitalized within the last year? ☐ Yes ☐ No

   From: ____ / ____ / ____ To: ____ / ____ / _____ Hospital Name: _____

   Address: _____

6. List your medical history during the **last two years** below, starting with most recent treatment.
(Please attach additional pages if necessary.)

Name of Physician:_____

Phone: (_____) _____ Address*:* _____

City: _____ State: _____ Zip: _____

Condition(s) treated:_____ Date(s): _____

Name of Physician:_____

Phone: (_____) _____ Address*:* _____

City: _____ State: _____ Zip: _____

Condition(s) treated:_____ Date(s): _____

Name of Physician:_____

Phone: (_____) _____ Address*:* _____

City: _____ State: _____ Zip: _____

Condition(s) treated:_____ Date(s): _____

7. Please complete the information in either Box A or Box B for services already provided.
(Please attach additional pages if necessary.)

A. NURSING HOME OR ASSISTED LIVING FACILITY CONFINEMENT:

Name of Facility:_____ Tax ID: _____

Contact Person, if known: _____

Address*:* _____ City:_____ State:_____ Zip:_____

Phone Number: (_____) _____ Fax Number: (_____)_____

Admitted: ___/ ____/_____ Discharged:____/ ____/ ____ Payer Source: _____

B. HOME HEALTH CARE, ADULT DAY CARE OR OTHER CARE SERVICES:

Name of Care Provider: _____ Tax ID: _____

Contact Person, if known: _____

Address*:* _____ City:_____ State:_____ Zip:_____

Phone: (_____) _____ Fax: (_____)_____

Admitted: ___/ ____/_____ Discharged:____/ ____/ ____ Payer Source: _____

8. Do you currently have coverage for medical care under Medicare?
(If yes, is coverage for Part A or Part B only, or for both?)

☐ Part A only ☐ Part B only ☐ Parts A&B ☐ No Medicare Coverage

Has a claim been submitted? ☐ Yes ☐ No

9. Do you have any other insurance that may provide coverage? **Check all that apply:**

☐ Coverage under a Medical Plan
Company _____ Policy Number: _____
Phone Number: (_____) _____ Has a claim been submitted? ☐ Yes ☐ No

☐ Medicare Supplemental Policy
Company _____ Policy Number: _____
Phone Number: (_____) _____ Has a claim been submitted? ☐ Yes ☐ No

☐ Other Third Party Coverage (Auto Insurance, Injury/Accident, Property Insurance, etc.)
Company _____ Policy Number: _____
Phone Number: (_____) _____ Has a claim been submitted? ☐ Yes ☐ No

☐ Workers' Compensation
Company _____ Policy Number: _____
Phone Number: (_____) _____ Has a claim been submitted? ☐ Yes ☐ No

☐ Other Long-Term Care Insurance
Company _____ Policy Number: _____
Phone Number: (_____) _____ Has a claim been submitted? ☐ Yes ☐ No

☐ No Insurance

☐ Unknown

10. Do you have a Power of Attorney, Conservator, or Guardian or other person who can legally represent you?* **If Yes, who?**

Name: _____ Phone Number: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

***Please attach to this form a copy of the document giving this person legal authority.**

For your protection some states require us to inform you that any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed. If we determine that benefits have been paid under this coverage as a result of your fraudulent action(s), we have the right to recover those benefit amounts. We may recover those benefit amounts directly from you or by reducing any subsequent benefit payments under this coverage. We will determine the manner in which we seek recovery of benefit payments made under fraudulent conditions.

I declare that all of the above answers are complete and true to the best of my knowledge and belief. I understand that the company reserves the right to require further proof.

X _____ _____/_____/ _____
Signature of Policyholder (or Legal Representative) Date signed (Month/Day/Year)

_____ _____
Policyholder (or Legal Representative) Name (Please Print) Signed at (City, County, State)

_____
If Legal Representative, give relationship to Policyholder

AK residents: 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.

AZ residents: 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.

AL residents: 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.

AR / LA and RI residents: 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.

CA residents: 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.

CO residents: 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.

DC residents: 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.

DE residents: A 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.

FL residents: 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.

ID residents: 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.

IN residents: 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.

KY residents: 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.

MD residents: 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.

ME / TN / VA and WA residents: 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.

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

NH residents: Any person who, with the 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.

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

NM residents: 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.

NY residents: 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.

OH residents: 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.

OK residents: 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.

PA residents: 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.

PR residents: Any person who, knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony, and upon conviction shall be sanctioned for each violation with the penalty of a fine of not *less* than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravated circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TX residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prision.

WV residents: 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.

All other states residents: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

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ADDRESS CHANGE REQUEST

All address change requests must be submitted in writing. Use this form to request a permanent change of address. Please allow 30 days for the address change to be processed.

Policyholder's Name: _____

Claimant's Name: _____

Policy Number(s):

_____ _____

_____ _____

PLEASE CHANGE MY ADDRESS TO:

Address: _____

City: _____ State _____ Zip code _____

Effective Date of Change:_____
(This address change will remain in effect until further written notification is received.)

Name of person completing this form (please print): _____

_____ _____
Signature of Policyholder (or Legal Representative) Date Signed (Month/Date/Year)

_____ _____
Policyholder (or Legal Representative) Name (Please Print) Signed at (City/County/State)

_____
If Legal Representative, give relationship to Policyholder
(Attach a copy of your legal authority, Power Of Attorney, guardianship, etc. if applicable)

PLEASE NOTE:

This address change will affect all correspondence being sent to the policyholder by Bankers, such as: Premium Statement, Claim Checks, Explanation of Benefits (EOB).

This form **must be signed and dated by the policyholder or Legal Representative** in order to be considered valid. Without proper signature(s) or documentation, this document is null and void.

If you have further questions please feel free to contact our Customer Service Department at 1-800-621-3724 between the hours of 8:00 AM – 4:30 PM Central Time, Monday through Friday.

Please mail Address Change Request Form to:

Policy Benefits Department
PO Box 1902
Carmel, IN 46082-1902
Or
Fax to: 312-396-5952