Standard Life & Accident Insurance Company

Critical Illness Claim Form

MAIL PROCESSING CENTER, P.O. BOX 10546, SPRINGFIELD, MO 65808-0546 Toll-Free (888)350-1488 Fax (866) 490-3164

CLAIMANT INFORMATION

1. Policy or Identification Number:	2. Name of patient:	4. Patient's Date of Birth:
	3. Name of insured:	

MEDICAL INFORMATION

5. Nature of and extent of your critical illness:	6. On what date was the condition diagnosed?
7. On what date did symptoms begin?	8. Please describe these symptoms:
9. Name of doctor who first treated you for this condition:	10. Doctor's address and phone number:
11a. Have you undergone any tests related to your condition? Yes No	11b. If yes, please give details and dates:
12a. Have you previously suffered from, or received treatment for, a similar or related condition? Yes No	12b. If yes, please provide details:

13. I declare the answers and statements herein to be true. I hereby authorize the use or disclosure of my health information as described in this authorization. Standard Life and Accident Insurance Company or its Agent acting on its behalf is authorized to receive and use the information to determine payment or for other health care operations. This Authorization is for the release of all Medical Records for diagnosis and treatment during the last five (5) years. Health Information may be used for Claim Processing and/or Care Management. The Authorization for Release of Health Information expires one (1) year from the date this authorization is signed.

Signature ________________________ Date ____________ Tel. No. ____________

Address ____
Street City State Zip

THIS FORM MUST BE SIGNED BY THE PATIENT. A PARENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS A MINOR.