



BOSTON MUTUAL LIFE INSURANCE COMPANY  
120 Royall Street • Canton, MA 02021

**CLAIM APPLICATION FOR**  
**CRITICAL ILLNESS AND/OR HEALTH SCREENING BENEFIT**

**INSTRUCTIONS FOR FILING A CRITICAL ILLNESS CLAIM**

1. Please complete Section 1 - Policyholder/Claimant's Information section.
2. Please complete Section 2 – Critical Illness Information section. (If additional space is needed to include all names of doctors or hospitals, please attach a separate piece of paper)
3. Please read and sign the appropriate HIPAA compliant authorization. (The authorization will help us obtain any additional medical information needed to complete the processing of your claim. Failure to sign the authorization could delay the processing of your claim)
4. Have your attending physician complete the Critical Illness Attending Physician's Statement that corresponds to the specific critical illness for which the claim is being made.

If you are filing for cancer under the critical illness plan, please attach the pathology report that confirms the diagnosis.

**INSTRUCTIONS FOR FILING A HEALTH SCREENING CLAIM**

1. Please complete Section 1 - Policyholder/Claimant's Information section.
2. Please complete Section 3 - Health Screening Information section.
3. Attach medical documentation which indicates the type of test performed and the date the test was performed.

**INSTRUCTIONS FOR FILING A CANCER EXPENSE BENEFIT (If applicable)**

1. Please complete Section 1 - Policyholder/Claimant's Information section.
2. Please complete Section 2 – Critical Illness Information section.
3. Attach copies of the Eligible Medical Expenses incurred. (Please refer to your policy for a description of the Eligible Medical Expenses)

If you should need assistance in the completion of this claim form

Please call (800) 669-2668 ext. 368

**\*\*\*SEND COMPLETED CLAIM FORM TO ABOVE ADDRESS\*\*\***



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? <input type="checkbox"/> YES, WHEN _____ <input type="checkbox"/> NO	DIAGNOSIS (INCLUDING COMPLICATIONS)	
CANCER/CARCINOMA IN SITU			
DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED)		WAS THE CANCER/CARCINOMA IN SITU <input type="checkbox"/> PATHOLOGICALLY DIAGNOSED, OR <input type="checkbox"/> CLINICALLY DIAGNOSED	
IF THE CANCER/CARCINOMA IN SITU WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA IN SITU 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 PATIENT'S 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.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
2. WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHOSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3. DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4. DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?	<input type="checkbox"/> YES	<input type="checkbox"/> 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.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
WHAT CONDITION CAUSED THE NEED FOR CORONARY ARTERY BYPASS SURGERY?		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, LUNG, KIDNEY, OR PANCREAS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> 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 VERTEBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY.		<input type="checkbox"/> YES	<input type="checkbox"/> 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.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?)			
RENAL FAILURE			
DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS)			
WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE?		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 ZIPCODE
SIGNATURE		DATE	MEDICAL ID#

## FRAUD WARNING NOTICES

For use with Claim Forms

### PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**ALASKA:** 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.

**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.

**ARKANSAS:** 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.

**CALIFORNIA:** For your protection California law requires the following to appear on this form:  
Any person who knowingly presents a 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 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.

**DELAWARE:** 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.

**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.

**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.

**IDAHO:** 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.

**INDIANA:** 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.

**KENTUCKY:** 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.

**LOUISIANA:** 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.

**MAINE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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 HAMPSHIRE:** Any person who, with a 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 RSA 638:20.

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

## FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

### PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

**NEW MEXICO:** 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.

**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 such 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.

**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.

**OREGON:** 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 may be guilty of insurance fraud.

**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.

**PUERTO RICO:** 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 dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**RHODE ISLAND:** 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.

**TENNESSEE:** 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.

**TEXAS:** Any person who knowingly presents a 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.

**VIRGINIA:** 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.

**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.

**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.

**ALL OTHER STATES:** 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.



## **NOTICE OF INFORMATION PRIVACY PRACTICES**

### **Boston Mutual Life Insurance Company (Herein referred to as “we”, “us”, “our”)**

Your privacy is important to us. We believe in ensuring the privacy of the information you give to us. This notice describes our privacy practices.

We restrict access to your non-public personal information (“*information*”) about you. We restrict it to those employees who have a need to know it. They need it to provide products and services to you. To protect your information, we maintain: physical; electronic; and procedural safeguards.

#### **COLLECTING INFORMATION**

We collect financial and health information about you in order to conduct business. Such uses are: to process requests for insurance products; to provide customer service; to process claims; to fulfill legal and regulatory requirements; and for other lawful purposes. We collect this information from you as well as from other sources.

Information we need to collect varies according to the products and services you request. It may include information from:

- your applications and other forms.
- other transactions you’ve had with us.
- consumer reporting agencies.
- your medical providers and health records.
- other sources.

#### **SHARING INFORMATION**

We treat the information we have collected about you in a confidential way. We do not disclose information about our customers or former customers to anyone, except as permitted or required by law.

We may share your information with third parties without your authorization as permitted by law. Such information is used to:

- process or service your insurance transactions with us.
- perform underwriting, administrative, account maintenance and claims functions.
- provide customer service or reinsurance coverage.
- protect against fraud.
- or perform other business functions on our behalf.

We may also share your information with:

- a consumer reporting agency in accordance with the Fair Credit Reporting Act.
- a third party to comply with federal, state or local laws, subpoenas or summonses.
- or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential; and to comply with all applicable federal and state privacy laws.

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (*TTY 866 346-3642*). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Boston Mutual Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

#### **ADVERSE UNDERWRITING DECISION**

You have the right to be advised in writing of the specific reasons for an adverse underwriting decision. Such decisions include:

- declining your application for insurance.
- offers to insure you at a higher than standard rate.
- termination of your coverage.

You must request this information in writing within 90 days from the date we mail you notice of the decision. We will furnish you with a statement of the specific reason for our decision within 21 days of receiving your written request for it.

#### **ACCESS TO YOUR PERSONAL INFORMATION WE HAVE IN OUR RECORDS**

You have the right to obtain access to all the information we have on you. You have the right to request: the amendment; correction; or deletion of such information. To do so, write us at the address below.

If you have questions about this notice or wish more information about our privacy policies, please write us at:

**Boston Mutual Life Insurance Company**  
Attention: Privacy Office  
120 Royall Street, Canton, MA 02021