VB Cancer Claim Form



The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as "We or "ManhattanLife"

Life, Specified Disease/Critical Illness, Hospital Indemnity, and Accident Insurance products insured by ManhattanLife Insurance Company.

Insured Statem	nent				
Section I – General					
Section 1 – Seneral	i illioilliation.				
Is the claim for the:	Policyholder	Dependent			
Policyholder's Name				Policy No.	
Date of Birth/	_/ Social Security	No	_ Mailing		
Address		City			State
ZIP Code					
Daytime Telephone No.	()				
Claimant Name				_ Date of Birth	
Travel Expenses* Please check the type of	travel benefits you are cla	aiming for:			
Meals	Use of Personal Vehicl	le Lodging	g Expenses fo	r Common Carrier	Transportation
Please check who accon	npanied you for your canc	er treatment:			
Attended Alone	Spouse or Fri	end Child	Multiple Adu	lts and Children	
*Benefit may not be availab	le for all plans. Please refer	to your Policy Certificat	e for specific benefits.		
	ntent to defraud or knowing t tive statement may be subje				
	6)				
Statements on page 5 and	6) are true to the best of m	าy knowledge and be	elief.		
Statements on page 5 and		ny knowledge and bo	elief.		



- Sign and date the authorization on page 3 and include when returning the claim form.
- A copy of the pathology report with a definitive cancer diagnosis is required.
- Your policy may also require UB04 and/or HCFA 1500 forms to be submitted, please consult your policy certificate for details



Section II – Physician Information:

Attending (Treating) physicians:

Physician's Name	Address	Phone Number
ne claimant ever been treated for th	e same or a similar condition in the past? Yes No	0
ne claimant ever been treated for the prior physician	·	0
	·	Phone Number
please provider the prior physician	n(s) information:	
please provider the prior physician	n(s) information:	
please provider the prior physician	n(s) information:	

If the claim is being filed for services within the first 2 years following the policy effective date, complete the physician and medication information below:

Physician information:

List all physicians that treated the patient in the five years prior to the policy effective date:

Physician's Name	Address	Phone Number	Reason for Visit

Medication information:

List all medication being taken by the patient:

Medication	Prescribing Physician	Date Prescribed



	uthorization to release information - For the Uatient's Name	Jse and Disclosur	_	alth Information		
TC pro ad ag	D: Any physician, medical practitioner, hospital, phovider of medical or dental services or supplies; a lministrator, administrator, The Index System, bus pencies, educational institutions, or any Federal, Suministration and Veterans Administration.	any employer, gro siness entities, fina	other medical or nup policyholder, co ancial institutions,	nedically-related ontract holder or consumer report	insurer, benefit plar ing	_
Ιa	authorize the use and/or disclosure of my protecte	ed health informati	on and other relate	ed information as	s described below:	
1.	My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.					o
2.	I authorize all health care professionals to disclo	se my protected h	ealth information to	ManhattanLife I	nsurance Company	,
3.	My authorization applies to work information and records, client lists, any and all other work-related coverage and claims filed, including all records a	d information for co	ontractual work per	formed; informat	0 .	е
4.		•	-		-	
_	and payment amounts, entitlement dates and en			•	•	4
5.	I authorize only designated staff of ManhattanLif receive, in writing, by photocopy, facsimile, or by				nsurance Company	to
6. 7.	privacy protection regulations, such information in	may be re-disclose	ed and would no lo	nger be protected	d.	
	addressed to ManhattanLife Attn: Claims Depar effective on the date it is received by Manhattan the extent that the persons I have authorized to upon this Authorization.	rtment PO Box 920 Life Insurance Co	6169 Houston, TX mpany. I am awar	77092 . This rev re that my revoca	ocation shall becom	to
Th	nis Authorization is given in connection with a cla	aim for benefits. I	intend that it be va	alid for the durati	ion of the claim.	
Αį	photocopy or facsimile of this authorization shall	I be valid as the o	riginal.			
	ertify that I have received a copy of this Authealth information as contemplated herein for			and/or disclosu tes of service _		
				/	/	
Si	gnature	Printed Name		Date		
	nave legal authority* under the laws of the State	nom the use and	or disclosure of	protected healt	ecisions on behalf h information abov	
ар	oplies, and execute this Authorization in my capa	acity as Authorize	d Representative	thereot.		
<u> </u>	The state of the s	Deletie	A 1' 1	/	/	
	ame of Authorized Representative/Parent Guardian	Relationship to A	Applicant	Date		

Mail to: ManhattanLife VB Claims PO Box 926169 Houston, TX 77092

*A copy of the legal authority document must be on file with ManhattanLife.

Customer Service: 1-855-448-6982

Or Fax to: 1-502-405-7107

Email to: vbclaimssubmissions@manhattanlife.com



Cash Cancer Claim Form - Attending (Treating) Physician Statement

Section I – Patient Information:					
Patient's Name	Policy No				
Street Address					
City	State	ZIP Code			
Section II – Treatment Information:					
Diagnosis or Condition for this patient			ICD'9/ICD'10 Code		
Date the symptoms first appeared:/_			Date of the first visit:/		
Date of the definitive diagnosis of Cancer:	/				
Has this patient been treated for this same or a similar condition prior to this occurrence? Yes No					
If yes, list the date(s) of prior treatment:					
Was this patient referred to you? ☐ Yes	□ No				
If yes, please provide the referring physician information:					
			Phone No. ()		
Referring Physician Address					
Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on pages 5-6)					
The above Statements are true to the best of my knowledge and belief.					
Printed Name of Physician		P	hone No. ()		
SpecialtyStreet	Address				
CitySta	te	ZIP Code	_		
Signature of Physician			/ Date//		

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Email to: vbclaimssubmissions@manhattanlife.com

A copy of the pathology report is required to review for Cash Cancer benefits.

Your policy may also require UB04 and/or HCFA 1500 forms to be submitted, please consult your policy certificate for details



State Specific Fraud Warning Statements

ManhattanLife:

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:

Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

Alabama:

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.

Arkansas, Louisiana, 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.

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 statement 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 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

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.

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.



State Specific Fraud Warning Statements

Kansas:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maryland:

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.

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 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.

Virginia:

Any person who, with the 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 have violated the state law.