National General
Accident & Health

For plans underwritten by:
National Health Insurance Company,
Integon National Insurance Company,
Integon Indemnity Corporation,
or Time Insurance Company

CLAIM FILING KIT FOR CRITICAL ILLNESS AND CANCER AND HEART/STROKE

FILING INSTRUCTIONS:

National General Accident & Health requires all records related to the covered accident be submitted with this claim form. Claims will not be eligible for review until all required documents are received. It is your responsibility to provide the following to us:

1. COMPLETED CLAIM FORM. Complete the attached Critical Illness Claim Form in its entirety
   - HIPAA AUTHORIZATION. Must be signed by patient or guardian if a minor.
   - PHYSICIAN STATEMENT. Must be completed and signed by your treating physician
2. MEDICAL NOTES:
   - CANCER CLAIMS. A pathology report showing the positive diagnosis of cancer and the date of diagnosis
   - CRITICAL ILLNESS and HEART/STROKE CLAIMS. All medical records associated with the illness, from the provider

SUBMIT ALL DOCUMENTATION TO:

Mail:

National General Accident and Health
P.O. BOX 3252
Milwaukee, WI 53201-3252

Or fax to: 317-284-7281

Once we receive the required documentation we will begin the claim review process in accordance to the provisions of the policy. Completing and submitting the requested documentation is not a guarantee of benefits. Always refer to your policy documents for the complete listing of benefits, limitations and exclusions.

If you have any questions, please contact National General at 1-855-323-4750

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CRITICAL ILLNESS and CANCER and HEART/STROKE CLAIM FORM

PLEASE COMPLETE ALL SECTIONS

SECTION 1 – GENERAL INFORMATION TO BE COMPLETED BY POLICY OWNER

CRITICAL ILLNESS AND OR CANCER AND HEART/STROKE POLICY NUMBER: _____

POLICY OWNER FULL NAME_____

STREET ADDRESS: _____

CITY: _____ STATE:: _____ Zip: _____

TELEPHONE NUMBERS: HOME: (_____) _____ - _____ WORK: (_____) _____ - _____ CELL: (_____) _____ - _____

EMPLOYER: _____

OCCUPATION: _____

NATURE OF ILLNESS: _____

PART 2 – STATEMENT OF LOSS TO BE COMPLETED BY INSURED OR CLAIMANT IF OTHER THAN INSURED

CLAIMANT FULL NAME:

_____

DATE OF BIRTH: _____ / _____ / _____ (MM / DD / YY)

RELATIONSHIP TO POLICYOWNER: SELF SPOUSE SON DAUGTHER OTHER (Circle One)

If other, define _____-

DESCRIBE SICKNESS:

_____

DATE FIRST CONSULTED PHYSICIAN FOR THIS CONDITION: _____ / _____ / _____ (MM / DD / YY)

PRIMARY CARE PHYSICIAN NAME _____

PHYSICIAN ADDRESS _____

_____PHONE (_____) _____ - _____

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HAVE YOU EVER HAD THIS CONDITION BEFORE? YES_____ NO_____

IF YES, WHEN? _____ / _____ / _____ (MM / DD / YY)

LIST ALL PHYSICIANS WHO HAVE TREATED YOU FOR THIS CONDITION (INCLUDE NAME, ADDRESS & TELEPHONE NUMBER):

_____

_____

_____

THE FOLLOWING AUTHORIZATION MUST BE SIGNED BY PATIENT BEFORE CLAIM CAN BE PROCESSED

Any person who knowingly, and with intent to defraud, or deceive an insurance company, who files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud. Insurance fraud is a felony.

Please refer to the State Specific Fraud Statements at the end of this packet.

HIPAA AUTHORIZATION

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me to provide all such information as may be requested by National Health Insurance Company, Integon National Insurance Company, Integon Indemnity Corporation or Time Insurance Company (collectively hereafter "National General"), its legal representative or any medical records retrieval service National General may engage, including but not limited to EMSI. This authorization includes any and all information you have about me, including but not limited to information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information also may be disclosed to any medical records company engaged by National General, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by such regulation, all information received by National General pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as the original. I understand that this authorization is required in order to enable National General to make payment determinations relating to me and/or my minor children. I may refuse to sign this authorization; however, National General may not be able to make a payment determination without the required information. I understand that I may revoke this authorization at any time by notifying National General in writing of my desire to revoke. Such revocation must be sent by certified mail to Privacy Office, National General at PO Box 3252, Milwaukee, WI 53201-3252. Such revocation will not be valid if National General has taken action in reliance on the authorization. Unless an earlier date is required by law, this authorization expires when I am no longer a policyholder of National General.

_____

Signature of Patient (Parent if Child, Executor, POA, or Surviving Spouse (Supporting Documentation Required) Date

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SECTION 3: PHYSICIAN STATEMENT

The treating physician must complete this section and submit completed form and all supporting documentation of the diagnosis to National General by faxing to (317)284-7281.

LAST (PATIENT) _____FIRST (PATIENT) _____MI_____

PATIENT BIRTH DATE_____ / _____ / _____ (MM / DD / YY) PATIENT GENDER MALE_____ FEMALE_____

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION_____ / _____ / _____ (MM / DD / YY)

DATE PATIENT WAS FIRST DIAGNOSED WITH THIS CONDITION_____ / _____ / _____ (MM / DD / YY)

IF HOSPITALIZED, PLEASE PROVIDE DATES _____ / _____ / _____ THROUGH _____ / _____ / _____

APPLICABLE DIAGNOSIS CODES_____

APPLICABLE PROCEDURE (CPT) CODES_____

NAME/ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED_____

HAVE YOU PREVIOUSLY TREATED THIS PATIENT? YES____ NO_____

(IF YES, PLEASE PROVIDE THE ILLNESS AND DATES TREATED) ___/___/_____ THROUGH ___/___/_____

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITIONS? YES____ NO_____

IF YES, PROVIDE DATES AND DESCRIBE _____ / _____ / _____ THROUGH _____ / _____ / _____

_____

DOES THE PATIENT SUFFER FROM ANY CHRONIC ILLNESSES? YES____ NO_____

(IF YES, PLEASE IDENTIFY ILLNESSES)_____

DOES THE PATIENT TAKE ANY PRESCRIPTION MEDICATION REGULARLY? YES____ NO_____

(IF YES, PLEASE IDENTIFY THE MEDICATIONS)_____

HAS ANY OTHER PHYSICIAN EVER TREATED THE PATIENT FOR THIS CONDITION? YES____ NO_____

NAME AND ADDRESS OF PHYSICIAN WHO PREVIOUSLY TREATED THIS PATIENT

_____

_____

NAME AND ADDRESS OF REFERRING PHYSICIAN_____

REFERRING PHYSICIAN'S PHONE (_____) _____ - _____

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SECTION 3: PHYSICIAN STATEMENT, continued

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PHYSICIAN'S NAME — PRINTED

_____

ADDRESS (INCLUDING CITY, STATE AND ZIP CODE)

_____ _____

PHYSICIAN'S PHONE NUMBER (_____) _____ - _____ PHYSICIAN'S FAX NUMBER (_____) _____ - _____

PHYSICIAN'S SIGNATURE (INCLUDING DEGREES AND CREDENTIALS)

_____Date_____

Please submit completed Physician Statement form and
all other supporting documentation of the diagnosis
to National General by faxing to (317)284-7281.

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STATE SPECIFIC FRAUD STATEMENTS

The law in ALASKA states: "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."

For your protection the law in ARIZONA states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

The law in ARKANSAS states: "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.

For your protection the law in CALIFORNIA states: "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."

The law in COLORADO states: "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.

The law in DELAWARE states: "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."

The law in the DISTRICT OF COLUMBIA states: "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."

The law in FLORIDA states: "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.

The law in IDAHO states: "Any person who knowingly, and with intent to defraud or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading, information is guilty of a felony."

The law in INDIANA states: "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."

The law in KENTUCKY states: "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."

The law in LOUISIANA states: "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."

The law in MAINE states: "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.

The law in MINNESOTA states: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

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The law in NEW HAMPSHIRE states: "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."

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

The law in NEW MEXICO states: "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."

The law in NEW YORK 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 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."

The law in OHIO states: "Any person who, with 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 is guilty of insurance fraud."

The law in OKLAHOMA states "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."

The law in PENNSYLVANIA 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 act, which is a crime and subjects such person to criminal and civil penalties."

The law in RHODE ISLAND states: "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."

The law in TENNESSEE states: "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."

The law in TEXAS states: "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."

The law in VIRGINIA states: "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."

The law in WASHINGTON states: "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."

The law in WEST VIRGINIA states: "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."