USAble Life

WELLNESS BENEFIT CLAIM FORM

Submitting a Wellness Claim To file for your Wellness Benefit Claim, complete this form, front and back, in full. Failure to complete this form may cause a delay in the processing of your claim. Please keep a copy of this completed form along with the supporting documentation for your records. Additional documentation such as receipts are not required. Sign, date, and submit by email, fax or traditional mail. Contact information for each form of submission is located on the second page of this form.

Please note: Your policy may not cover all of the examinations and treatments listed below. For an accurate list of examinations and treatments covered by your policy, please reference your certificate of insurance.

Policyholder Information (please print)

Policy Number

Policyholder SSN

Policyholder First Name

MI

Last Name

Policyholder DOB (MMDDYYY)

Policyholder Mailing Address City

State

Zip Code

Policyholder Telephone

Ext. (if applicable)

Patient Information (please print)

Patient First Name

MI

Last Name

Patient DOB (MMDDYYY)

☐ Self ☐ Spouse ☐ Dependent

Relationship to Policyholder (please check one)

Testing/Treatment Information (please print)

Medical Facility Where Performed

Medical Facility Telephone

Performing Physician's Name

Medical Facility Mailing Address

State

Zip Code

Date of Treatment (MMDDYYY)

Test Performed (please check one)

☐ Colonoscopy	☐ EKG	☐ CEA (blood test for colon cancer)	☐ Flexible Sigmoidoscopy	☐ Pap Smear- ThinPrep
☐ Dental X-Ray	☐ Breast MRI	☐ CA 125 (blood test for ovarian cancer)	☐ Thermography	$ Actual Cost of Pap Smear (PA residents only)
☐ Vision Exam	☐ Cancer Prevention Vaccine/ Immunizations	☐ Biopsy	☐ Chest X-Ray	☐ Mammogram
☐ Ultrasounds	☐ CA 153	☐ Hemocult Stool Specimen	☐ PSA (blood test for prostate cancer)	$ Actual Cost of Mammogram (PA residents only)

Note: Some test listed above may not be covered under all policies. If you are unsure of the tests or treatments covered by your plan, please consult your policy or contact our customer service department at 800-370-5856.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state or local), reinsurer, or other organization, institution or person that has information, records or knowledge or me or my health, past or present, to furnish such information to USAble Life (the "Company") or its agents. I authorize the Company to disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge that I have a right to a copy of this authorization upon request.

FRAUD WARNING: 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.

Date of Signature (MMDDYYY)

Signature of Patient or Parent/Guardian (if patient is a minor)

WELLNESS BENEFIT CLAIM FORM MAILING & CONTACT INFORMATION

SUBMIT CLAIM FORM TO:

Mail: USAble Life Claim Department

P.O. Box 1650

Little Rock, AR 72203-1650

Fax: (501) 235-8400

Email: claims@usablelife.com

FOR QUESTIONS OR ASSISTANCE CONTACT:

USAble Life Customer Service

Phone: 1-800-370-5856

8:00 a.m. - 4:30 p.m. Central Time

Email: custserv@usablelife.com