



COMBINED BENEFITS GROUP, INC.

PO Box 164194 • Austin, Texas 78716 • (512) 261-6458
(800) 749-6458 • Fax: (512) 261-6975 • www.cbg-online.com

Tips for Filing for Cancer Benefits

How to file your initial claim:

- 1) Complete all sections of the attached claim form.
- 2) It is not required that the medical provider complete the claim form.
- 3) Attach a copy of the pathology report(s) with a positive diagnosis of cancer or a specified disease.
- 4) Expenses are based on medical treatment of cancer and specified diseases. Be sure to attach a copy of your itemized expenses with your claim, if available.
- 5) Mail the completed claim form to:
Conseco
Attn. Claims
PO Box 2012
Carmel, IN 46082

How to file subsequent claims:

To file for additional benefits, once your claim has been approved, simply submit copies of your itemized bills along with a cover sheet that clearly identifies the policy holder. You can use the initial claim form as a cover.

Itemized bills/statements:

Itemized bills/statements are available from the billing department of your provider. These expenses should illustrate the amount billed and any days of hospital confinement. Do not submit copies of your insurance carriers Explanation of Benefits (EOB). The itemized bill should come from the provider.

Questions Regarding Benefits/Claims:

You may check on your claim at any time by calling Conseco at 800-749-6458. A representative will be happy to assist. Should you have questions regarding your benefits or need assistance with your claim, call our office at 800-749-6458.

CLAIMANT'S STATEMENT CANCER INSURANCE ONLY

VULCAN LIFE INSURANCE COMPANY
 CVIC LIFE INSURANCE COMPANY
 CONSECO LIFE INSURANCE COMPANY
 PHILADELPHIA LIFE INSURANCE COMPANY
 WABASH LIFE INSURANCE COMPANY
 P.O. Box 2012
 Carmel, IN 46082-2011



CONSECO

This claim form is to be used only for claims, which are being filed under Cancer Policies. To establish a claim and avoid delay, A POSITIVE PATHOLOGY REPORT MUST ACCOMPANY THIS FORM

Policyowners Name	Policy No.	Telephone No.
Address	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	

1. If Claim is on a dependent, please give: _____

Date of Birth _____ Relationship: Spouse Child Stepchild Common-law Spouse

If Claim is on a dependent child over age 19 or 21 (depending on limiting age as described in your policy):

- A. Is child a full-time student? Yes No
- B. Is child physically handicapped? Yes No
- C. Is child mentally retarded? Yes No
- D. Is child married? Yes No

If answer to A, B, C, or D is yes, complete documentation concerning the situation must be submitted with this claim form in order to establish a valid claim.

2. What is the nature of this illness? _____

3. What date were symptoms first noticed? _____

4. If hospitalized, give dates of confinement. _____

5. Please provide name and address of primary physicians:

_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Has claimant had cancer of any type in the past? Yes No If yes, please provide details of such illness and names and addresses of attending physicians. Please provide exact dates. Details:

Name _____	Name _____	Name _____
_____	_____	_____
_____	_____	_____

7. Has claimant had a previous claim number? Yes No If yes, please provide claim number _____

We hereby certify the foregoing statements and answers are true and complete to the best of our knowledge and belief.

We hereby authorize any insurance company, prepayment organization, employer, union, trust fund, hospital, physician, druggist or any other person to release all information to the Life Insurance Company with respect to us or any of our dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization shall be considered as effective and valid as the original.

Date: _____ Signature of Policyowner _____

Date: _____ Signature of Spouse _____

Some states, including but not limited to Florida, Kansas, Kentucky, Minnesota, Ohio, and Oklahoma, require a statement such as the following:

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 claim containing a false or deceptive statement is guilty of a crime.

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