



1. PLEASE FULLY COMPLETE THIS FORM  
 2. ATTACH ITEMIZED BILLS  
 3. MAIL TO HSR  
 E-mail: [UBAclaims@hsri.com](mailto:UBAclaims@hsri.com)



HSR Plaza II  
 4100 Medical Parkway  
 Carrollton, Texas 75007  
 Phone: (972) 512-5600 Fax: (972) 512-5820  
 Toll Free (866) 523-3452

Policy Name:  
**United Business Association**  
 Policy Number:  
**HASA-1000**

## Critical Illness Claim Form

1. Claimant's Name (Insured)		2. Social Security Number	3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of Birth	5. E-Mail
6. Address of Claimant and Best Contact Phone Number (Include Area Code)					
7. If claim is on a dependent please complete the following: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner/ Civil Union <input type="checkbox"/> Child/Stepchild			8. Dependent's Name		
9. Dependent's Date of Birth	10. Dependent's Social Security Number	11. Dependent's Address if Different			

### Critical Illness Information

- Invasive Cancer:** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of local or distant tissue. The term Invasive Cancer also includes Leukemia, Lymphoma and malignant melanoma with a maximum thickness of 10 mm as determined by histological examination using the Breslow Method.
- Heart Attack (Myocardial Infarction):** The death of a portion of the heart muscle resulting from blockage of one or more coronary arteries
- Stroke:** The death of brain tissue due to a cerebrovascular event resulting in neurological damage including infarction, hemorrhage or embolization of brain tissue from an extra cranial source for at least 60 days.

See your policy for complete benefits and exclusions

12. Describe condition or illness

13. Date you were first seen for this condition	14. Confirmed diagnosis date	15. Have you ever been hospitalized for the same or similar condition <input type="checkbox"/> Yes <input type="checkbox"/> No
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16. If Yes to question 15 provide name and address of hospital

17. Reason for prior hospitalization

18. Are you currently hospitalized for your current condition?  
 Yes  No

19. If yes to question 18 provide name and address of hospital

20. Name and address of treating physician

21. Signature of claimant

22. Date

In order to process your claim additional documentation may be required.  
 Medical records, pathology reports, office visit notes, EKG scans and/or various other records

Please complete and return page 3 along with this claim form so we may request these documents on your behalf

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

## FRAUD WARNING NOTICES

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.

### STATE SPECIFIC PROVISIONS

Alabama	<b>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.</b>
Alaska	<b>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.</b>
Arizona	<b>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.</b>
Arkansas	<b>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.</b>
Louisiana	<b>For your protection California law requires the following 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.</b>
California	
Colorado	<b>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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.</b>
Delaware	<b>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.</b>
Idaho	<b>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.</b>
District of Columbia	
Florida	<b>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.</b>
Hawaii	<b>For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.</b>
Indiana	<b>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.</b>
Kentucky	<b>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.</b>
Maine	<b>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 denial of insurance benefits.</b>
Maryland	<b>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.</b>
Minnesota	<b>A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.</b>
New Hampshire	<b>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 section 638:20.</b>
New Jersey	<b>Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.</b>
New Mexico	<b>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.</b>
New York	<b>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.</b>
Ohio	<b>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.</b>
Oklahoma	<b>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.</b>
Oregon	<b>Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.</b> <b>In order for us to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on your part, we must show that:</b> <b>A. The misinformation is material to the content of the policy;</b> <b>B. We relied upon the misinformation; and</b> <b>C. The information was either:</b> <b>1. Material to the risk assumed by us; or</b> <b>2. Provided fraudulently.</b>
	<b>For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on your part must either be fraudulent or material to our interests.</b>
	<b>Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.</b>
Pennsylvania	<b>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.</b>
Rhode Island	<b>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.</b>
Tennessee	<b>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.</b>
Virginia	
Washington	

# Authorization for Release of Medical Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

I, \_\_\_\_\_ patient of \_\_\_\_\_ (physician name) am authorizing Health Special Risk, Inc. to use and/or disclose my health information as identified below to:

Name of Provider: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

For the following purpose(s): Describe each purpose; if requested by the patient, you may state "at patient's request"

- All Records from \_\_\_\_/\_\_\_\_/\_\_\_\_ (date) to \_\_\_\_/\_\_\_\_/\_\_\_\_ (date)
- Initial Exam Records
- All Office Records
- All Hospital Records
- Laboratory / Pathology Reports
- Billing / Financial Statements

\_\_\_\_\_(Initials) I DO  or I DO NOT  consent to the release of information relating to psychiatric or psychological testing, alcohol and / or drug abuse diagnosis, prognosis and treatment and /or HIV (AIDS) testing and/or results.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

This consent shall become invalid **180** days from the date signed unless a different expiration date, event or condition is specified. Specify:

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
2. I have the right to receive a copy of this authorization.
3. A copy or facsimile of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Individual or Individual's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name or Print Name of Legal Representative

\_\_\_\_\_  
Relationship to Individual

**Mail To: Health Special Risk, Inc  
4100 Medical Parkway, Ste 200  
Carrollton, Texas 75007**

**or**

**Fax to: 972-512-5820**

**Phone: 800-328-1114**