

CANCER SCREENING REIMBURSEMENT CLAIM FORM (C09)

Routine cancer screenings can play an important role in achieving and maintaining a healthy lifestyle. Early detection of cancer often leads to additional treatment options and a greater chance of fighting this disease. Because we care about you and know the importance of these screenings, we have made the claim filing process easy for you!

If you have one of the cancer screening tests listed below, you can elect to not submit a copy of the medical bill and simply complete this claim form and then fax or mail it to us. We'll promptly review your claim for benefits! If your cost for the cancer screening test exceeds the amount shown below (up to \$100), you can send us a copy of the medical bill along with this form. If you have a cancer screening test not listed below, a copy of the medical bill is needed for us to review your claim for benefits. Please complete a separate claim form for each family member. You may fax this form to us toll-free at 1-888-453-5127. Or if you prefer, you can mail it to us at the above address.

If you have any questions, please feel free to call and speak to any one of our Customer Service Representatives at 1-800-541-2363, extension 6001, from 7:30 a.m. to 5:00 p.m. Central Standard Time.

To Be Completed By Insured

Insured's Name : _____ CSO Policy Number: _____

Insured's Address: _____

Claimant's Name: _____ Claimant's Date of Birth: _____

Relationship to Insured: _____ Date of Test: _____

Name of Physician: _____ Physician's Phone Number: (____) _____

Physician's Address: _____

Your CSO Cancer policy will pay the amount charged up to a maximum of \$100 per calendar year for each insured person who has cancer screening tests performed while this policy is in force. Many of the common cancer screening tests are listed below. We have indicated next to each test the amount we will pay for the test if you do not send us a copy of the medical bill. Please refer to your policy for benefits and limitations.

- Please check the Cancer Screening Test(s) received by you or a covered family member on the above date.

<input type="checkbox"/> Mammography/breast ultrasound \$75	<input type="checkbox"/> CEA (blood test for colon Cancer) \$50
<input type="checkbox"/> Pap smear/Thin Prep Pap (test only) \$25	<input type="checkbox"/> Colonoscopy \$100
<input type="checkbox"/> CA 125 (blood test for ovarian Cancer) \$50	<input type="checkbox"/> Chest X-ray \$50
<input type="checkbox"/> PSA (blood test for prostate Cancer) \$50	<input type="checkbox"/> Thermography \$50
<input type="checkbox"/> Hemocult stool specimen \$10	<input type="checkbox"/> Serum protein electrophoresis \$25
<input type="checkbox"/> Flexible sigmoidoscopy \$100	

I certify that the above statements are true and correct and hereby authorize any physician or other health care provider to give CSO any additional information needed in connection with this claim. If a special authorization is required by my physician to confirm the above information, I will promptly complete any authorization requested of me and return to CSO.

Date: _____ Claimant's Signature: _____
Or Parent/Guardian If Claimant Is A Minor

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.