aetna®

Senior Supplemental Insurance

P.O. Box 14862
Lexington, KY 40512
800-264-4000

Claim Form

from **Continental Life Insurance Company of Brentwood, Tennessee**

An Aetna Company

• Print clearly and use blue or black ink.

Policyholder information

All information requested in this form must be completed before your claim can be considered.

Full name of policyholder *First, M.I., Last*

Policy number

Policyholder address

City | State | Zip

Is the claimant deceased? ○ Yes ○ No

If "yes," what is the name and relationship of person completing this form:
Please provide a copy of the death certificate

What was the medical diagnosis? ○ Cancer ○ Heart Attack ○ Stroke

What is the name and address of the claimant's primary care physician?

What is the name and address of the doctor who made the diagnosis?

Names of any other doctors who attended for this condition

What other doctors have been consulted or given treatment during past five years?

Name of doctor	Address	Ailment/nature of treatment

Is this a claim for intensive care unit (ICU) benefits? ○ Yes ○ No

If "yes," provide the name and address of the facility, the doctor's name and the reason for being placed in ICU.

Statement of attending physician

Print clearly and use blue or black ink.

To the physician:
Please make your report as comprehensive as possible, giving exact dates. Narrative information will assist in a clear understanding of the full nature and history of the disability. **Supporting documentation are helpful and will prevent delays and requests for additional information.**

- **First occurrence cancer** – pathology report or clinical diagnosis containing office notes.
- **Heart/stroke** – Medical diagnosis containing office notes.
- **ICU** – Statement from hospital containing room and board description and number of days confined (i.e. itemized bill or claim form).

1. Full name of attending physician *First, M.I., Last*
2. How long have you been the patient's doctor?
3. Please describe fully the nature of the illness or injury with a complete diagnosis:
4. Date you first attended the patient for this condition:
5. Was the patient previously diagnosed with the same or similar condition? ○ Yes ○ No
   If "yes," please provide date of previous diagnosis:
6. Did you order hospitalization of the patient? ○ Yes ○ No
   If "yes," what hospital?
7. Were tests done? *Please send pathology report if any.* ○ Yes ○ No
   If "yes," when? When was testing advised?
8. Are there any medications currently prescribed by a doctor? ○ Yes ○ No
   If "yes," what medications? Reason for taking medication
9. Have other doctors treated the patient in the past? ○ Yes ○ No
   If "yes," please provide doctors' names, addresses, phone numbers, dates of consultations and the reason for the visits below or on a separate attachment:

Must be furnished under authority of law.

The hospital is hereby authorized to furnish all requested information with the policyholder's consent.

Attending physician signature — Date

X

Individual practitioners – Social Security number:

All others – employer identification number:

Office address — City — State — Zip