SNI CRITICAL ILLNESS CLAIM FORM

Please read the important information below:

- Please be sure your member ID is written on this form.
- The claim must be filled out and signed by the primary member.
- If the claim is for a dependent child under the age of 18 the form and authorization must be signed by the primary member.
- The authorization to release health information must be signed, dated and included with your claim form, so that we can contact your medical provider(s) on your behalf if additional medical documentation is required in reviewing your claim. Please note, sometimes certain medical providers will not accept authorization and will require their own special release authorization to be completed. If this should happen, we will advise you.

- We ask that you please do not submit copies of other insurance carriers Explanation of Benefits Statements (EOB) and or Provider Account Balance Due Statement(s), as they do not always include the required information (diagnosis code, procedure code, dates of service) that we need in order to review and process your claim. If they are submitted, it can result in the rejection and/or delay of your request.
- For your records, we suggest you make copies of any information you send us.

Please send the completed claim form, signed HIPAA Authorization, itemized bills, and death certificate (if applicable) to:

Sovereign Nations Insurance
PO Box 1810
Draper, UT 84020
OR Fax to: 801-274-8900
OR Email to:
customerservice@sniprotect.com

INSTRUCTIONS FOR FILING A CLAIM DUE TO CANCER, HEART ATTACK, OR STROKE

CANCER OR SKIN CANCER (MALIGNANT MELANOMA ONLY) CLAIMS:
Submit the pathology report diagnosing cancer. This must accompany your initial claim. The hospital, doctor or pathology laboratory will furnish this report to you at your request. If the diagnosis of cancer was not made by pathological means, please submit the clinical evidence that established a positive diagnosis of cancer.

HEART ATTACK CLAIMS:
Submit electrocardiogram (EKG) or echocardiogram (ECG) results, cardiac enzyme (troponin) lab results, if available any cardiac catheterization report, the admission and discharge summaries of your hospital confinement.

STROKE CLAIMS:
Submit the Computerized Axial Tomography (CAT scan), a Magnetic Resonance Imaging (MRI) and/or Magnetic Resonance Angiography (MRA) results, the admission and discharge summaries or your hospital confinement if hospitalized, any speech, occupational or physical therapy evaluation notes.

CLAIMS FOR DECEASED:
Please submit a copy of the Death Certificate, Power of Attorney and Estate Documents.

For assistance, please contact our Customer Service Department 844-200-8820

SNI CRITICAL ILLNESS CLAIM FORM

TO BE COMPLETED BY THE MEMBER

Primary Member Information			
Name of Member:		Member ID#:	
DOB:	Phone:	Email: (Please provide for faster service)	
Street:	City:	State:	ZIP:

Patient Information (Please fill out if different than Primary Member)		
Name:		Relationship to Primary:
DOB:	Gender: ☐ Male ☐ Female	Email: (If different than the Primary)

TYPE OF CLAIM(S)

- ☐ Cancer (malignant melanoma/adenocarcinoma)
- ☐ Advanced Stage Cancer (Stage III or Stage IV)
- ☐ Heart Attack (myocardial infarction)
- ☐ Stroke/CVA (cerebral vascular accident)

Date of First Symptom	Date of First Physician Visit	Date of Actual/Definitive Diagnosis
Have you had this illness/condition before? ☐ Yes ☐ No		If yes, date?

If yes, whats the name, address, and telephone number of the physician?

Name: *Phone:*

Address:

If hospitalized for this illness/condition, what's the name and address of the hospital/medical center?

Name: *Phone:*

Address:

Primary Care (family doctor) name, address and telephone number:

Name: *Phone:*

Address:

Were there any other physicians seen during the last two (2) years? ☐ Yes ☐ No

If yes, please provide their names, addresses, and phone numbers:

Name: *Phone:*

Address:

Name: *Phone:*

Address:

PLEASE BE ADVISED THAT IF THE ABOVE INFORMATION (PROOF OF DIAGNOSIS) IS NOT INITIALLY ACCOMPANIED WITH YOUR CLAIM SUBMISSION, IT CAN DELAY THE REVIEW AND PROCESSING OF YOUR CLAIM.

YOUR ENROLLMENT HAS A PRE-EXISTING CONDITION(S) LIMITATION. THEREFORE, IF YOU WERE DIAGNOSED WITHIN 12 MONTHS OF YOUR EFFECTIVE DATE, THEN THERE IS NO COVERAGE WITHIN THE FIRST 12 MONTHS. IN ADDITION TO THE PRE-EXISTING CONDITION LIMITATION THERE IS ALSO AN INITIAL WAIT PERIOD OF 60 DAYS. MEMBERS CANNOT SUBMIT A CLAIM THAT OCCURS DURING THE FIRST 60 DAYS OF THE POLICY.

I understand that this information will be used by Sovereign Nations Insurance for the purpose of evaluating my claim request. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of the authorization upon request.

Member Signature **Print Name** **Date**

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by SNI for purposes of obtaining information necessary to process a claim for coverage.

Member ID #:	

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, insurance company, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Sovereign Nations Insurance or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for verifying eligibility or claims processing and information provided to any affiliated third party on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for coverage. Revocation requests must be sent in writing to the attention of the Claims Processor.

I understand that Sovereign Nations Insurance may condition my claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by SNI in accordance with federal or state law.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

(Print Please) Name of Member **Date of Birth**

Signature of Member **Date**

(Print Please) Name of Authorized Representative, or Next of Kin

Relationship of Authorized Representative or Next of Kin to Member

Signature of Authorized Representative or Next of Kin **Date**