Critical Illness Claim Filing Instructions

Underwritten by: MetLife Insurance Company
Administered by: Bay Bridge Administrators LLC

Page 1 – Insured's Statement of Claim:

Must be completed each time you file a claim.
Be sure to answer every question.

Page 2 – Authorization

Claimant or Authorized Representative must sign and date Authorization on page 3 to allow physicians to release medical records to Bay Bridge Administrators, L.L.C.

Page 3 – Pre-existing Investigation Form

If claim is being filed within the first year of the policy and is for an illness, please complete this page with all physicians seen or medications taken in the past 12 months.
If provider fax numbers are known, please provide them in order to expedite this process.
Please make certain authorization on page 3 is signed and dated.

Please attach itemized billings, from your providers that include dates of service, diagnosis and procedure codes.

ALL REQUIRED PORTIONS OF THIS CLAIM FORM MUST BE COMPLETED TO AVOID UNNECCESARY DELAY IN THE PROCESSING OF YOUR REQUEST FOR BENEFITS.

Return fully completed claim form and supporting documentation by mail or fax to:
Bay Bridge Administrators L.L.C.
PO Box 161690
Austin TX 78716
512-275-9350 (fax)
For questions call: 800-845-7519

Claim Form for **Critical Illness** *no claim form required if filing for wellness benefit only*	**Underwritten by: MetLife Insurance Company** **Administered by: Bay Bridge Administrators, LLC** **PO Box 161690** **Austin TX 78716** **800-845-7519**

INSURED'S STATEMENT OF CLAIM

Name of Insured:	Insured's Date of Birth:	Policy Number:
Street Address		Phone Number (area code first):
Name of Claimant:	Claimant's Date of Birth:	Relationship to Insured:

Type of Critical Illness for which claim is being made	Date that Critical Illness was first diagnosed:	Date you were first treated for your illness or injury:

Describe the onset and nature of your Illness or Injury:

_____

_____

_____

_____

_____

_____

Have you ever had the same or a similar condition in the past? __Yes __No Date _____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address
Have you ever had the same or a similar condition in the past? __Yes __No Date_____	Treated by: Hospital: _____ Name Address Doctor: _____ Name Address

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.

The above Statements are true to the best of my knowledge and belief.

_____ _____

Signature of Insured **Date**

AUTHORIZATION

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. Only this information may be used and/or disclosed pursuant to this authorization.

2. I authorize all health care professionals to disclose my protected health information.

3. I authorize only designated staff of Bay Bridge Administrators, L.L.C. to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Bay Bridge Administrators, L.L.C. This revocation shall become effective on the date it is received by Bay Bridge Administrators, L.L.C. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

6. This Authorization is valid for twelve (12) months from the date of execution hereof.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS AUTHORIZATION AND AUTHORIZE THE USE AND/OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS CONTEMPLATED HEREIN.

_____ _____ _____
Signature Print Name Date

I have legal authority* under the laws of the State of _____ to make health care decisions on behalf of_____, the individual to whom the use and/or

Disclosure of protected health information above applies, and execute this Authorization in my capacity as Authorized Representative thereof.

_____ _____ _____
Name of Authorized Representative Relationship to Applicant Date
Parent or Guardian

*A copy of the legal authority document must be on file with Bay Bridge Administrators, L.L.C.

If claim is being filed during the first year of the policy, please complete the following and sign and date the authorization on the preceding page.

Please list all physicians that treated the patient in the last year:

Physician's Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____
Approximate Date Consulted: _____ Diagnosis: _____

Physician's Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____
Approximate Date Consulted: _____ Diagnosis: _____

Physician's Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____
Approximate Date Consulted: _____ Diagnosis: _____

Physician's Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____
Approximate Date Consulted: _____ Diagnosis: _____

Please list all prescribed medications now being taken by patient:

Name of Medication	Prescribing Doctor	Date First Prescribed

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 subject to prosecution and punishment for insurance fraud.

Claim Form for **Critical Illness**	**Underwritten by: MetLife Insurance Company** **Administered by: Bay Bridge Administrators, LLC** **PO Box 161690** **Austin TX 78716** **800-845-7519**

To Be Completed By the Medical Provider.

1. Provide the diagnosis(es), the date of diagnosis, and the ICD-10 code(s) for the conditions for which you are treating this patient.

2. Has this patient been treated for this same or similar condition in the past prior to this occurrence? ☐Yes ☐No

If yes, please provide diagnosis, the dates of treatment and referring physician(s).

_____

_____

_____

_____

_____

_____

_____

_____

3. Please provide the name and address of any referring physician(s) for this occurrence.

_____

_____

_____

_____

Medical Provider's Name (Please Print) Phone Number Fax Number

Medical Provider's Signature Date

_____ _____

Physician's Statement – continued

Claimant Name:_____ Policy/Certificate #:_____

For each condition below for which you are treating this patient, please enclose the information listed under the Medical Documentation Needed section.

If you require prepayment, please contact us at 1-800-845-7519. Otherwise, please bill our office.

Illness (not all illnesses are applicable to all policies.)	Medical Documentation Needed
Heart Attack	Diagnosis based on the following: new EKG changes consistent with and supporting the diagnosis of Heart Attack; elevation of cardiac enzymes above generally accepted laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used); imaging studies such as thallium scans, MUGA scans or stress echocardiograms.
Heart Transplant	Medical records that demonstrate Heart Failure of covered person; and proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human-to-human replacement of the whole heart.
Stroke	Documented neurological impairment or deficits; evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test); permanent neurological deficit measured two months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.
Coronary Artery Bypass Surgery	Operative report documenting major surgery requiring median sternotomy (division of breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist; results of angiography testing that diagnosed coronary heart disease.
Angioplasty	Coronary Angiography Report along with medical records from the hospital including the discharge summary, which indicates that the procedure was performed.
Invasive Cancer or Malignant Melanoma	Diagnosis based on pathologist's report or, in the event that the cancer was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of cancer.
Carcinoma in Situ	Diagnosis based on pathologist's report or, in the event that the carcinoma in situ was diagnosed without surgery, laboratory and x-ray examination reports used to make the definitive diagnosis of carcinoma in situ.
Major Organ Transplant	Medical records that demonstrate Major Organ Failure; and proof that covered person is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing organ.
End Stage Renal Failure	Documentation of chronic irreversible failure of both kidneys and proof of regular (at least weekly) renal dialysis.
Loss of Vision	Documentation of clinically-proven, irreversible reduction of sight in both eyes as a result of illness or injury. The corrected visual acuity must be less than 20/200 or a visual field restriction to 20 degrees or less in both eyes. There must be clear proof that blindness was due to illness or injury, and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis.
Loss of Speech	Documentation of clinically-proven total, permanent and irreversible loss of the ability to speak as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months; documentation regarding general medical opinion whether surgery, a device or implant could result in the partial or total restoration of speech. The diagnosis must be made by physical examination by a speech pathologist.

Loss of Hearing	Documentation of clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months after diagnosis. Documentation regarding general medical opinion, regarding whether surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing. The diagnosis must be made from physical examination by an audiologist.
Coma	Documentation that demonstrates a state of complete and continuous unconsciousness for a period of time, which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes. The diagnosis of Coma must be made by a board-certified Neurologist.
Severe Burns	Medical Records demonstrating that the covered person has sustained third degree burns covering at least a percentage of the surface area of His body. Third degree means the destruction of the skin through the entire thickness or depth of the dermis and the layer of tissue below the skin (subcutaneous tissue). The diagnosis of Severe Burns must be made by a physician board-certified in Plastic Surgery
Permanent Paralysis due to Accident	Documentation of Hemiplegia; Paraplegia; or Quadriplegia and that the loss is expected to be permanent; has been present continuously for at least 180 days; is caused by Injury sustained in an Accident occurring after the Effective Date of Insurance; evidenced by the total and irreversible loss of use of two or more limbs; and marked by loss of muscle function in two arms, two legs, or one arm and one leg. Paralysis does not included paralysis that results from a Stroke.
Occupational HIV benefit	Documentation demonstrating all of the following: that the Covered Person initially contracted and was diagnosed with Human Immunodeficiency Virus (HIV) after the Date of Certificate; that the cause of the HIV must be from an accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the twelve (12) months preceding diagnosis; results from blood tests performed within five (5) days of the accident and within twelve (12) months of the accident.
Alzheimer's Dementia	Medical Records demonstrating the loss of intellectual capacity involving impairment of memory and judgment as measured by cognitive and neuroradiological tests (e.g. CT scan, MRI, PET of the brain). Documentation should also demonstrate that this has resulted in significant reduction in mental and social functioning such that the Insured Person requires Substantial Assistance in performing at least three of the six Activities of Daily Living (as defined in this policy). The diagnosis must be made by a Physician board-certified in Neurology.
Loss of Independent Living Benefit	Medical Records demonstrating the inability to perform two or more Activities of Daily Living without Stand-by Assistance or a Cognitive Impairment.
Diabetes	Medical Records demonstrating the diagnosis for Type 1 or Type 2 Diabetes including the appropriate laboratory tests and physician treatment records, inclusive of all prescribed medications and supplies.
Wellness Benefit	Superbill or HCFA form from the physician indicating the preventative tests performed, including the procedure codes. The claimant's name and policy number should also be indicated on this documentation. No claim form is required.

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Bay Bridge Administrators L.L.C.
PO Box 161690
Austin TX 78716
512-275-9350 (fax)
For questions call: 800-845-7519

FRAUD WARNING

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: 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.

Colorado: 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine, Tennessee and Washington: 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 a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: 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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the 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 may have violated the state law.

Pennsylvania and all other states: 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.