



Statement of Wellness Test or Examination

Insured's Statement

Information about Patient

Name of Patient (Last, First, Middle Initial)		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Dependent Child			
Mailing Address	Street & Number	City	State Zip
			Primary Phone Number ()

Information about Employee/Primary Insured

Name of Member, if not the patient (Last, First, Middle Initial)		Date of Birth	Social Security Number
Mailing Address		Street & Number	City State Zip
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Phone Number ()	Cell Phone Number ()	Employer/Association	Policy Number

Information regarding the Wellness Test/Examination

Date of Wellness Test/Examination:

Please indicate the test or examination that was performed.

<input type="checkbox"/> Mammography	<input type="checkbox"/> Flexible Sigmoidoscopy	<input type="checkbox"/> Serum Protein Electrophoresis
<input type="checkbox"/> Chest X-Ray	<input type="checkbox"/> EKG	<input type="checkbox"/> Thermography
<input type="checkbox"/> Pap Smear	<input type="checkbox"/> Cholesterol and Diabetes Screening	<input type="checkbox"/> CA 15-3 for Breast Cancer
<input type="checkbox"/> Blood Test for Triglycerides	<input type="checkbox"/> Fasting Blood Glucose Test	<input type="checkbox"/> CA 125 for Ovarian Cancer
<input type="checkbox"/> Bone Marrow Testing	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Breast Ultrasound
<input type="checkbox"/> PSA (Blood Test for Prostate Cancer)	<input type="checkbox"/> CEA Blood Test for Colon Cancer	<input type="checkbox"/> Hemocult Stool Analysis

Information about Physicians and/or Hospital

Full name of treating physician		Specialty
Mailing Address (street, city, state, zip)	Phone Number ()	Fax Number ()

Additional Information

➤ Attach copies of all itemized bills related to this wellness test or exam including doctor and dates and details of the test or exam.

Acknowledgement

Only one Wellness Benefit will be paid per Insured Person per Calendar Year. If both you and your Spouse are each insured as a Primary Insured under your own Group Voluntary Accident Only coverage through this Policyholder, each Insured Person will only be eligible to receive a benefit under one Wellness Benefit Rider.

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 2 of this form.

▶ _____ ▶ _____
Employee's Signature Date

Please complete form and return with itemized bills described above.



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Insurance Fraud Warning

LifeMapCo.com

Unless specific state language is provided below, the following fraud notice applies: 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.

Arizona Residents: 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.

California Residents: 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.

Colorado Residents: 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.

District of Columbia Residents: 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.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: 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.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: 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 Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 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.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: 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.

Maine, Tennessee, Virginia and Washington Residents: 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.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: 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.