

# Employee Paid Supplemental Claim



### Instructions:

The purpose of this form is for the submission of additional documents after an initial claim has been filed. It can also be used to submit a claim for the Wellness Screening Benefit or the Cancer Screening benefit (Cancer policy). Complete one form for each family member.

Complete all applicable sections including the authorization section. **Attach a copy of the itemized bill, medical records or any other documentation to support this claim for benefits.** Documentation must include the name of the provider of service, the type of service and the date of service. See policy for details of covered items and services.

Submit this form and the accompanying documentation to the address, fax number or e-mail address stated at the bottom of this form.

### Employee Information

Insured Employee Name \_\_\_\_\_ Employer name \_\_\_\_\_ Employer Phone# \_\_\_\_\_  
Policy# \_\_\_\_\_ Social Security Number \_\_\_\_\_ Phone# \_\_\_\_\_  
Mailing Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

Are you still employed with Policyholder?  Yes  No Last day worked \_\_\_\_\_

### Please check the type of benefit you are claiming

- Accident policy Date of accident \_\_\_\_\_ Description of accident \_\_\_\_\_
- Cancer policy \_\_\_\_\_
- Cancer Screening \_\_\_\_\_
- Critical Illness policy \_\_\_\_\_
- Wellness Screening Benefit \_\_\_\_\_

Comments regarding this claim submission \_\_\_\_\_

### Claimant Information

This claim is for: Name \_\_\_\_\_  Self  Spouse  Dependent  
Claimant Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*(If different from above)*

### Physician Information

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_

### Hospital Information

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to Union Security Insurance Company, or its representative, any and all such information. **I UNDERSTAND** the information obtained by use of this authorization will be used by Union Security Insurance Company to determine the eligibility for benefits. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

If I receive a benefit greater than that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

Signature of claimant \_\_\_\_\_ Date \_\_\_\_\_

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