Mail or fax completed Claim Form to:
Attn: Claims
BCS Insurance Company
2 Mid America Plaza, Suite 200, Oakbrook Terrace, IL 60181
Phone: (877) 563-2367 Fax: (630) 869-0655

EssentialCare Group Hospital Indemnity Claim Form

DISCLAIMER:

In furnishing this form, BCS Insurance Company does not waive any of its rights or defenses, nor admit liability.

IMPORTANT CLAIM FILING INSTRUCTIONS:

- Please review carefully and fully complete the form. An incomplete form will delay the processing of the claim.
- **Enclose supporting documentation with your claim form.** Supporting documentation may include: medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical/hospital bills, medical EOBs, toxicology reports, childcare/transportation/lodging receipts, or police reports (if applicable following an accident).
- Submit the form and supporting documentation to:
    - Electronic: www.bcsgateway.com & submit via the **Message Center**
    - Fax: (630) 869-0655
    - Mail: Attn: Claims, BCS Insurance Company, 2 Mid America Plaza, Suite 200, Oakbrook Terrace, IL 60181

SECTION 1 – Employee/Policyholder Information

Provide details of the policyholder and insured

Employer Name _____ **Group Policy Number** _____

Employee/Insured Name *(First Name, Middle, Last Name)* _____

Phone Number _____ **Gender** ☐ Male ☐ Female

Address *(Street, City, State & Zip)* _____

Date of Birth *(mm/dd/yyyy)* _____ **E-mail Address** _____

Do you authorize the delivery of confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No **Via e-mail?** ☐ Yes ☐ No

If Yes to either personal cell phone or e-mail, please **initial here** to confirm your response: _____

Does the employee/insured have major medical insurance or other primary health insurance? ☐ Yes ☐ No
If Yes, provide name of insurance carrier and policy number: _____

Is the employee/insured currently actively working? ☐ Yes ☐ No
Hours Worked/Week: _____ If No, date last worked and reason: _____

SECTION 2 – Claimant/Patient Information

Complete if this claim is for a dependent of the employee/insured

Claimant/Patient Name *(First Name, Middle, Last Name)* **Date of Birth** *(mm/dd/yyyy)*

_____

Relationship (To Employee/Insured) **E-mail Address** **Phone Number**

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Check all that apply – I authorize the delivery of confidential medical or benefit information via personal cell phone and/or email?
☐ Personal cell phone ☐ E-mail

If Yes to either personal cell phone or e-mail, please **initial here** to confirm your response: _____

Complete Mailing Address *(Street, City, State & Zip)*

Is the child incapacitated/disabled? ☐ Yes ☐ No **Is the child married or in a partnership?** ☐ Yes ☐ No

SECTION 3 – Hospital Indemnity Claim Details

Please refer to your certificate for covered Accident claims

Please provide a detailed explanation of the hospitalization.

Was there a confinement? ☐ Yes ☐ No **If yes, select applicable** ☐ Hospital Confinement ☐ Continuous Care Confinement

Was the hospitalization the result of a pregnancy or delivery? ☐ Yes ☐ No

If yes, complete the following Pregnancy section. If no, continue to Section 4.

Date of Delivery/Expected Delivery Date

Type of Delivery/Expected Type of Delivery?
☐ Vaginal ☐ Elective C-section ☐ Unplanned C-section

First Day of Last Period?

Are/were there any complications of pregnancy? ☐ Yes ☐ No

If Yes, explain what and when:

Dates of Hospital Confinement (mm/dd/yyyy – mm/dd/yyyy)

SECTION 4 – Fraud Warning Notices

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NOTICE IN ALABAMA AND ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE IN ALASKA AND VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: 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.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN 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.

NOTICE IN DELAWARE: 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.

NOTICE IN DISTRICT OF COLUMBIA: 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.

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

NOTICE IN IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN INDIANA: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

NOTICE IN LOUISIANA, WEST VIRGINIA, RHODE ISLAND AND ALL OTHER STATES NOT LISTED SEPARATELY: 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.

NOTICE IN MAINE: 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.

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

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of

claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK: 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 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.

NOTICE IN OHIO: 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.

NOTICE IN 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.

NOTICE IN OREGON: Any person who knowingly presents a false statement of claim for insurance may be guilty of insurance fraud and subject to penalties under state law.

NOTICE IN PENNSYLVANIA: 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.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN 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 include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a 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.

SECTION 5 – Claimant Authorization to Obtain and Disclose Information

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (HIPAA).

By signing this authorization form, I agree to the following:
I authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medically-related facility, care provider or evaluator, insurance company, or insurance support organization that has such information, to disclose the following health information about me:

- Information as to the diagnosis, treatment or prognosis of my physical and mental health, including information related to office visits, prescriptions, outpatient treatments, medical test results and other similar information.
- Information about drug abuse, alcoholism, mental illness and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS) or sexually transmitted diseases. This authorization does not include psychotherapy notes. HIPAA's Privacy Rule requires a separate authorization for access to psychotherapy notes.

Such health information about me may be disclosed to BCS Insurance Company (BCS) and any representatives performing services for BCS, including its insurance support organizations, third-party administrators, affiliates, and any reinsurers. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask BCS to correct, amend or delete any incorrect personal information.

I acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. A copy of BCS' "Notice of Privacy Practices" is available upon request.

This authorization shall be valid for a period of 24 months from the date signed (in AZ, 180 days) (in VA, 30 months). A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to BCS' Administrative Office.

Although my signature on this form is voluntary, I understand that it is required to determine my eligibility for benefits under an insurance policy issued by BCS. Without my signature, or upon its revocation, I understand that my claim for insurance benefits may be denied. By signing, I also acknowledge that if a party or organization receiving my protected health information is not a health plan or health care provider, subject to federal health information privacy laws, then the information described above may be disclosed to others and no longer be protected by such laws. However, BCS does require its agents and service providers to protect the confidentiality of health information.

My signature below represents my acknowledgement, acceptance, and authorization for all statements above.

Print Claimant Name _____ **Date of Birth** _____

Claimant Signature *(if claimant is 18 or older)* _____ **Date** _____

Signature of Legal Guardian *(if claimant is under age 18)* _____ **Date** _____

Print Name of Legal Guardian *(if signing for claimant above)* _____ **Relationship to Claimant** _____ **Legal Guardian Phone Number** _____

Legal Guardian Address _____

SECTION 6 – Claimant Certification and Signature

Claimant Certification

By signing below, I hereby certify that:

1. The information provided on this form is true and complete to the best of my knowledge and belief; and
2. I have read and understand the "Important Notice—Fraud Warning Statements" that applies to my state of residence.

Claimant Signature _____

Date of Signature _____

Submit completed Claim Form, along with supporting documentation, to:

Electronic:

Log into the BCS Gateway portal at www.bcsgateway.com

Submit your documentation through the **Message Center**

Fax:

(630) 869-0655

Mail:

Attn: Claims

BCS Insurance Company

2 Mid America Plaza, Suite 200

Oakbrook Terrace, IL 60181

For questions, please contact BCS Customer Support at 877-563-2367, M-F, 7am-6pm CST

BCS Insurance Company
2 Mid America Plaza, Suite 200 | Oakbrook Terrace, IL 60181

ACH AUTHORIZATION FORM

Information

Name:	
Address:	
Contact Name:	
Phone:	
Email Address for remittance advice **(required)**:	

Above named individual/entity hereby authorizes BCS to originate Automated Clearing House electronic funds transfer (EFT) credit entries to account, as indicated below, for payment/reimbursement of goods and/or services.

Name on Bank Account:	
Bank Name:	
Bank Address:	
Account Number:	
ACH ABA Number:	
Account Type:	☐ Checking ☐ Savings

If you change banks or accounts, please provide at least thirty (30) days written notice.

Authorization:

_____	_____	_____
Authorized Name/Title	Authorized Signature	Date

Completed forms may be mailed or emailed to BCS.

Mail:
BCS Financial Corporation
Attention: Accounts Payable
2 Mid America Place Suite 200
Oakbrook Terrace, IL 60181

Email:
Accounts Payable
apinvoices@bcsf.com

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