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TheStandard®
Standard Insurance Company
866.851.5505 Tel 402.328.4029 Fax
PO Box 85508 Lincoln NE 68501-5508

Leon County School Board
Health Maintenance Screening Benefit Claim Form

Instructions

Please complete, sign and submit this form to the address or fax number stated at the top of this form. You will need to complete a separate form for each family member.

For specific information about your benefits, refer to your group insurance certificate. The group policy and certificate are the ultimate authority for Health Maintenance Screening Benefit claim decisions. If you need additional information, please contact your employer's benefit administrator or call the customer service line listed above.

For a prompt review of your claim, ALL of this form must be thoroughly completed and signed.

A. About the Insured

Full Name	Employer/Company Name	Group Policy No.	Date of Hire
	Leon County School Board	**164520**	
Social Security No.	Date of Birth	Sex ☐ Male ☐ Female	
Phone No. ( )	Email Address		
Mailing Address	City	State	ZIP

Complete each Benefit Information section below that apply.

Accident Benefits Information

Are you insured for Accident benefits? ☐ Yes ☐ No	Effective Date of Coverage ____/____/____
Coverage Type: ☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child ☐ Employee + Family	

Critical Illness Benefits Information *(Specified Disease in the state of Vermont)*

Are you insured for Critical Illness benefits? ☐ Yes ☐ No	Effective Date of Coverage ____/____/____
Coverage Type: ☐ Employee ☐ Employee + Spouse/Domestic Partner Dependent children automatically covered.	

Hospital Indemnity Benefits Information

Are you insured for Hospital Indemnity benefits? ☐ Yes ☐ No	Effective Date of Coverage ____/____/____
Coverage Type: ☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child ☐ Employee + Family	

B. Information about the Patient – Check One ☐ You ☐ Spouse ☐ Domestic Partner ☐ Child

If the Insured is the Patient, then you do not need to complete this section again.

Full Name	Social Security No.	Phone No. ( )
Email Address	Date of Birth	Sex ☐ Male ☐ Female

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C. Information about the Health Maintenance Screening Procedure(s) performed

Procedure	Date Performed (mm/dd/yy)	Procedure	Date Performed (mm/dd/yy)
Abdominal aortic aneurysm ultrasound		Comprehensive Metabolic Panel (CMP)	
ABI - Ankle Brachial Index screening for peripheral vascular disease		Electrocardiogram (EKG)	
		Hemocult stool analysis	
Biopsies for cancer		Hemoglobin A1C	
Bone density screening		Human Papillomavirus Vaccination (HPV)	
Breast ultrasound		Lipid panel	
CA 125 (blood test for ovarian cancer)		Mammography	
CA 15-3 (blood test for breast cancer)		Pap smears or thin prep pap test	
CEA (blood test for colon cancer)		PSA (blood test for prostate cancer)	
Colonoscopy		Stress test (bicycle or treadmill)	
Complete Blood Count (CBC)		Generally medically accepted cancer screening test*	

*Procedure is only available in the state of California.

D. Acknowledgement

I certify that the above statements are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

Signature of Insured _____ Date _____

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Some states require us to provide the following information to you:

ALABAMA, MARYLAND AND RHODE ISLAND 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.

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: 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.

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 the 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 an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree

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, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA 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 and subjects such person to criminal and civil penalties.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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