

BOSTON MUTUAL LIFE INSURANCE COMPANY



HOME OFFICE: 120 Royall Street • Canton, MA 02021

ADMINISTERED BY: PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

PO Box 34952 • Omaha, NE 68134-9832 – TEL 1-888-453-5120 • FAX 1-888-453-5127

FAMILY MATTERS. NO MATTER WHAT.

HEALTH SCREENING/WELLNESS RIDER BENEFIT CLAIM KIT

INSTRUCTIONS FOR FILING A HEALTH SCREENING/WELLNESS CLAIM

1. Please complete Section 1 - Claimant's Statement.
2. Please complete Section 2 - Testing Information.
3. Please review, sign and date the form.
4. **Attach medical documentation which indicates the type of test performed and the date the test was performed.**

SECTION 1 – CLAIMANT'S STATEMENT (Please Print)

Insured Name (<i>Last, First</i>)	Claimant's (<i>Patient</i>) Name	Policy/Certificate #
Address (<i>City, State, Zip</i>)		
Telephone Number	Claimant's Date of Birth (<i>mo-day-yr</i>)	Insured's Social Security #

SECTION 2 – TESTING INFORMATION

DATE TEST PERFORMED _____

WHICH SCREENING TEST DID YOU HAVE PERFORMED?

- | | | |
|--|---|--|
| <input type="checkbox"/> Stress Test on a Bicycle or Treadmill | <input type="checkbox"/> Hemocult Stool Analysis | <input type="checkbox"/> Chest X-Ray |
| <input type="checkbox"/> Serum Cholesterol Test or Lipid Panel
<i>(total cholesterol count)</i> | <input type="checkbox"/> C-Reactive Protein | <input type="checkbox"/> Colonoscopy |
| <input type="checkbox"/> CA 15-3 (<i>Blood Test for Breast Cancer</i>) | <input type="checkbox"/> Thermography | <input type="checkbox"/> Homocysteine Level |
| <input type="checkbox"/> Serum Protein Electrophoresis (<i>myeloma</i>) | <input type="checkbox"/> Bone Marrow Testing | <input type="checkbox"/> Electron Beam Tomography |
| <input type="checkbox"/> CEA (<i>Blood Test for Colon Cancer</i>) | <input type="checkbox"/> Mammography/Breast Ultrasound | <input type="checkbox"/> Electrocardiogram (EKG) |
| <input type="checkbox"/> PSA (<i>Blood Test for Prostate Cancer</i>) | <input type="checkbox"/> Blood Test for Triglycerides | <input type="checkbox"/> Oral Cancer Screening (<i>using ViziLite or other similar test</i>) |
| <input type="checkbox"/> Fasting Blood Glucose Test | <input type="checkbox"/> Flexible Sigmoidoscopy | <input type="checkbox"/> Biopsy for Skin Cancer |
| <input type="checkbox"/> CA 125 (<i>Blood Test for Ovarian Cancer</i>) | <input type="checkbox"/> Pap Smear (<i>including ThinPrep Pap Test</i>) | |

Please note: Not all tests listed above may be eligible for coverage. Please refer to your Policy/Certificate for a list of covered tests.

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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge.

Please refer to the "Fraud Warning Notices" insert for your state.

X _____
 Signature of Claimant Printed Name Date

For Claim questions, please call toll-free
1-888-453-5120