LUMP SUM CANCER CLAIM FORM

PART A	INSTRUCTIONS: Please complete this form and include the corresponding documents.
• LUMP SUM FIRST CANCER DIAGNOSIS ➔	▪ Pathology report indicating a positive diagnosis. ▪ Complete parts A-B-C of the claim form. ▪ Medical record before the policy's effective date. **Note:** Send documents via e-mail: segurodevidacommercial@medicalcardsystem.com

*** ANTI-FRAUD NOTICE ***

"Any person who knowingly and with intent to defraud submits false information on an insurance application or who submits, assists, or causes to submit a fraudulent claim for payment of a loss or other benefit, or submits more than one claim for the same damage or loss, commits a felony and, upon conviction, shall be penalized for each violation with a fine of not less than five thousand (5,000.00) dollars and not more than ten thousand (10,000.00) dollars or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances exist, the fixed penalty may be increased up to a maximum of five (5) years; if mitigating circumstances exist, it may be reduced to a minimum of two (2) years."

PART B — TO BE COMPLETED BY THE INSURED (PLEASE WRITE IN PRINT)

1. Policy number:	2. Policyholder's name:	3. Policyholder's Social Security number: ___ - ___ - ____
4. Patient's date of birth:	5. Patient's name:	6. Patient's Social Security number: ___ - ___ - ____
7. Home phone:	8. Mailing address:	9. Relationship with primary policyholder: ❑Spouse ❑Dependent child:
10. Office phone:		12. Date of diagnostic exam (Biopsy):
11. Email address:	13. Diagnosis:	

14. Have you ever received treatment or medical care for cancer conditions? ❑ Yes ❑No **If your answer is Yes, please explain:**

Certification and/or authorization:
I certify that all information provided by me in this form is true. I understand that the law imposes severe penalties, such as fines, imprisonment, or both at the discretion of the court, for providing false information to obtain insurance benefits. I authorize all physicians, hospitals, and other institutions that treated me, my spouse, or my dependent children to provide **MCS LIFE INSURANCE COMPANY** any information relevant to this request. I authorize my employer to provide **MCS LIFE INSURANCE COMPANY** any necessary information or documents to determine my benefits.

_____ _____
POLICYHOLDER'S SIGNATURE **DATE**

_____ _____
PATIENT'S SIGNATURE **DATE**
(Applies only when the person is of legal age)

PART C — TO BE COMPLETED BY THE ATTENDING PHYSICIAN (PLEASE WRITE IN PRINT)

1. Patient's name:	2. Diagnosis (ICD-9 o ICD-10):
3. When were symptoms first noticed? Date:	4. When did the patient first consult you about this condition? Date:

5. Has the patient ever had this or a similar symptoms before? ❑**Yes** ❑**No** (If the answer is **Yes**, describe it) Date**:** _____

6. Has the patient received treatment or medical care for cancerous conditions in the last five (5) years: ❑ **Yes** ❑**No** (If your answer is **Yes**, explain in detail):

7. Indicate date and results of pathology exam:

Date: _____ Results: _____

Any person, including insurance agent, broker or solicitor, physician, or any other health service provider, or employer, who knowingly makes or assists in making a false representation of facts or submits incomplete information for inclusion in an insurance application or in a report or statement (claim) related to such insurance, may be considered to have committed fraud for purposes of the Insurance Code (See Article 27.190 of the Insurance Code).

PHYSICIAN'S NAME (**WRITE IN PRINT**):	LICENSE NUMBER:	SPECIALTY:
PHYSICIAN'S MAILING ADDRESS:		

CERTIFICATION: I certify that the information provided above is based on reasonable medical probability and necessity and that it is true and correct to the best of my knowledge. I further **CERTIFY** that the patient under my care, as indicated herein, is not a spouse, consensual partner, or relative (direct or indirect) of the undersigned.

_____ _____ _____
PHYSICIAN'S SIGNATURE DATE OFFICE PHONE:

COMMENTS: _____