State Mutual Insurance Company

Platinum® SUPPLEMENTAL INSURANCE

WELLNESS RIDER CLAIM FORM

Claim Information

Policyholder Name: _____ Policy Number(s): _____

Policyholder Address: _____
Street City State Zip

Claimant Name: _____ Claimant Date of Birth: _____
MM/DD/YYYY

Healthy Lifestyle Benefit: (Must be 18+) Select one program type. Fill in all provider information and date of service. If eligible, this benefit is available once per calendar year.

Program Type: ☐ Gym Membership ☐ Weight Loss Program ☐ Smoking Cessation Program ☐ Physical Examination

Date of Service: _____ Provider Name: _____ Provider Telephone: (_____) _____

Healthy Screening and Diagnostic Test Benefit: Select all types of service performed on the same date. Fill in all provider information and date of service. If eligible, this benefit is available once per calendar year.

☐ A1C Check/Glucose
☐ Angiogram
☐ Biopsy
☐ Blood Test for Cardiac Enzymes
☐ Breast Ultrasound
☐ CA 125 (blood test for ovarian cancer)
☐ CA 15-3 (blood test for breast cancer)
☐ CAT/CT Scan
☐ CBC (Complete Blood Count)
☐ CEA (blood test for colon cancer)
☐ Chest X-Ray
☐ Colonoscopy/Virtual Colonoscopy
☐ Complete Metabolic Panel
☐ Echocardiogram
☐ Electrocardiogram (EKG/ECG)
☐ Estrogen Profile
☐ Flexible Sigmoidoscopy
☐ Heart Catheterization
☐ Hemoccult Stool Analysis
☐ HDL/LDL/Triglyceride Panel
☐ HIV Antibody
☐ Immunization
☐ Liver Enzymes
☐ Mammography
☐ MRI
☐ Neuroimaging Studies
☐ Pap Smear
☐ Physical Examination
☐ Partial Thromboplastic Time (PTT)
☐ Prothrombin Time (PT)
☐ PSA Test
☐ Rheumatoid Arthritis Factor
☐ Sleep Study
☐ Stress Test (bicycle or treadmill)
☐ Testicular Ultrasound
☐ Testosterone Count
☐ Thallium Scan
☐ Thermography
☐ Thyroid Panel
☐ Vitamin D 25- Hydroxy

Date of Service: _____ Provider Name: _____ Provider Telephone: (_____) _____

Physician Office Visit Indemnity Benefit: (*Injury is excluded in Colorado*.) Select one reason for visit. Fill in all provider information and date of service. If eligible, this benefit is available 4 times per calendar year.

Reason for Visit: ☐ Injury ☐ Sickness

Date of Service: _____ Provider Name: _____ Provider Telephone: (_____) _____

Acknowledgement

All benefits of this Rider are per Covered Person and are subject to the terms, definitions, provisions, limitations, and exclusions of the policy to which it is attached**.** Any person who knowingly files a statement of claim containing false, incomplete or misleading information may be subject to civil and criminal penalties. The Provider listed above is authorized to validate the information I have provided.

Signature: _____ Date: _____
MM/DD/YYYY