CRITICAL ILLNESS
CLAIMS FORM

breckpoint®
LEAD TOGETHER

Please review your policy for specific benefits covered under your plan.
To prevent processing delays, please have claim form completed in full and return the signed HIPPA.
Please submit medical documentation from your healthcare provider to support your claim.
Email completed forms to claims@breckpoint.com

Employers Name	Social Security No.	Date of Birth	Gender

Insured's Medical Insurance Provider	Insured's Medical ID#	Insured's Email

Insured's Name	Insured's Address, City, State, Zip Code ☐ Check Box if this is a Permanent Address Change	Telephone Number

Patient's Name	Relationship to Insured	Date of Birth	Gender

By providing your Breckpoint email address above, you consent to the use of electronic transactions in connection with your Breckpoint policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that Breckpoint is, or may be, legally required to deliver to you).

Cancer;Carcinoma in situ: Please submit a copy of the pathology report, chart notes, and history & physical report.

Heart Attack: Please submit a copy of the pathology report, chart notes, and history & physical report.

Stroke: Please submit a copy of the MRI and/or CT test reports from the initial diagnosis, as well as proof of permanent neurological damage (i.e. follow up CT and/or MRI reports, office notes from neurologist or therapist, etc.)

End Stage Renal Failure: Please submit proof of the start date for dialysis or the operative report for transplant. The End Stage Renal Disease Medical Evidence Report is preferred.

* **Reoccurance Benefits (limit 2).**

I hereby certify that the answers I have provided to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

INSURED'S SIGNATURE: _____ DATE: _____

PATIENT'S SIGNATURE: _____ DATE: _____

CRITICAL ILLNESS
CLAIMS FORM

breckpoint®
LEAD TOGETHER

ATTENDING PHYSICIAN'S STATEMENT		
Patients Name:		Date of Birth:
When did signs and/or symptoms first appear?	Has the patient ever received medical advice or treatment for this or a similar condition? ☐ NO ☐ YES, WHEN	Diagnosis (including complications):

CANCER/CARCINOMA IN SITU	
Date of Diagnosis (the date the pathological specimen(s) were obtained on which Cancer or Carcinoma in SITU were diagnosed):	Was the Cancer / Carcinoma in SITU ☐ Diagnosed Pathologically ☐ Clinically Diagnosed
If the Cancer / Carcinoma in SITU was pathologically diagnosed, attach a copy of the pathology report. If the Cancer / Carcinoma in SITU was clinically diagnosed, please provide the reason(s) that pathological diagnoses was not obtained and attach medical evidence that supports the Diagnosis of Cancer.	

HEART ATTACK		
Does the patient's condition meet all of the following criteria:		
☐ YES	☐ NO	Are new and serial Electrocardiographic (EKG) finding consistent with myocardial infarction? Attach a copy of the EKGs and reports
☐ YES	☐ NO	Were cardiac enzymes elevated above generally accepted laboratory levels of normal for Creatine Physphokinase (CPK), a CPK-MB measurement must be used? Attach a copy of the lab report.
☐ YES	☐ NO	Did diagnostic studies confirm a Myocardial Infarction and the occlusion of one or more Coronary Arteries? Attach copies of any applicable reports.
☐ YES	☐ NO	Did the patient have chest pain consistent with Myocardial Infarction?
Date of Diagnosis (the date the patient met all of the above criteria for Myocardial Infarction):		

INVASIVE CANCER		
☐ YES	☐ NO	Did the patient undergo surgery to remove or stop the spread of cancer cells? If so, attach a copy of the operative report.
Date the patient was first treated for signs and symptoms of this condition:		

STROKE		
☐ YES	☐ NO	Did the patient have a stroke, meaning Apoplexy, secondary to rupture or acute occlusion of a Cerebral Artery? Stroke does not include transient ischemic attacks and attacks of vertebrobasilar ischemia, head injury, or chronic cerebrovascular insufficiency.
Date of diagnosis (the date a stroke occurred based on documented neurological deficits and neuroimaging studies:		

END STAGE RENAL FAILURE		
☐ YES	☐ NO	Does the patient have end stage renal failure presenting as chronic, irreversible failure to function of both kidneys?
☐ YES	☐ NO	Does the patient's kidney failure necessitate regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) or which results in kidney transplantation? If yes, attach a copy of End Stage Renal Disease Medical Evidence Report.

What is the cause of the patient's renal disease?	Date of diagnosis (the date the doctor or physician recommends that the patient begin renal dialysis:	Date the patient first treated for signs or symptoms of this condition:

ATTENDING PHYSICIAN'S SIGNATURE			
I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.			
Name (Attending Physician) Please Print:	Tax ID Number:	Phone:	
Address:	City:	State:	Zip code:
Signature:		Date:	

5130 South Fort Apache #215-365, Las Vegas, NV 89148 ◂ (844) 798-4878 ◂ claims@breckpoint.com
To review claims status and verify eligibility please visit your Claims Member Portal. portal.breckpoint.com

HIPPA AUTHORIZATION
TO OBTAIN INFORMATION

breckpoint®
LEAD TOGETHER

Send to:

Breckpoint Inc.
5130 South Fort Apache
#215-365
Las Vegas, NV 89148

Phone: (844) 789-4878
Email: claims@breckpoint.com

Primary Certificate Holder:	SSN (Optional):	Date of Birth:	
Certificate Number(s):			
Address:	City:	State:	Zip code:
Name of Individual Subject to Disclosure (If not the Primary Certificate Holder):		Date of Birth:	
Relationship to Primary Certificate Holder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild			

I. Authorization:
For the purpose of evaluating my eligibility for insurance and for benefits under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information (defined below) about me and, if applicable, my dependents, from the sources listed below to Breckpoint, or any person or entity acting on its part.

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including Breckpoint or additional coverages) or healthcare clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Breckpoint will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that Breckpoint has taken action in reliance on this authorization. If I revoke this authorization, Breckpoint may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to Breckpoint at the address above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that Breckpoint is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
• If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form
• If records are on a minor child the natural parent or legal guardian must sign on their behalf.

_____ _____
Signature of Individual Subject to Disclosure | Date Signed:

_____ _____ _____ _____
Legal Representative's Printed Name | Legal Representative's Signature | Legal Relationship | Date

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)