WELLNESS & HEALTH SCREENING CLAIMS FORM

breckpoint®
LEAD TOGETHER

FAILURE TO COMPLETE ALL SECTIONS MAY RESULT IN DELAYED PROCESSING OF THIS CLAIM. REVIEW YOUR POLICY FOR SPECIFIC BENEFITS COVERED UNDER YOUR PLAN.

AUTHORIZATION

I have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, consumer report agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information for me, to give to Breckpoint or its legal representative, any and all such information. This information is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug or alcohol abuse, treatment, prescriptions, testing, and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. I UNDERSTAND the information obtained by the use of the Authorization will be used by Breckpoint to determine eligibility for benefits under an existing certificate. Any information obtained will not be released by Breckpoint to any person or organization EXCEPT to re-insuring companies, or other person or organization performing business or legal service in connection with any claim, or as may otherwise lawfully require or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that this authorization shall be valid for the duration of my claim.

Insured's Signature: ______________________________ Date: ______________

Insured's Signature: ______________________________ Date: ______________

INSURED/PATIENT INFORMATION

Employer's Name:	Insured's Email:		
Insured's Medical Insurance Provider:	Medical ID #:		
Insured's Name:	Social Security Number:	Date of Birth:	Gender:
Insured's Address, City, State, Zip:			
Patient's Name:	Date of Birth:	Gender:	Insured's Phone #:

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

HEALTH SCREENING INFORMATION

Date Health Screening was performed:
Which Health Screening Test Did You Have Performed? (Attach a copy of itemized statement or invoice reflecting health screening performed.)

WELLNESS BENEFIT OF $50 ONCE PER YEAR PER EMPLOYEE AND PER SPOUSE

- ☐ Biopsy for Skin Cancer
- ☐ Blood Test for Triglycerides
- ☐ Bone Marrow Testing
- ☐ Chest X-ray
- ☐ Colonoscopy
- ☐ Doppler Screening for Carotides
- ☐ Doppler Screening for Peripheral Vascular Disease
- ☐ Sampling of blood or tissue to test for genetic susceptibility for the risk of cancers:
  - CA 15-3, Breast Cancer
  - CA 125, Ovarian Cancer
  - CEA, Colon Cancer
- ☐ Echocardiogram
- ☐ EKG (Electrocardiogram)
- ☐ Flexible Sigmoidoscopy
- ☐ Hemoccult Stool Analysis
- ☐ HPV (Human Papillomavirus) vaccine
- ☐ Lipid Panel (Total Cholesterol Count)
- ☐ Mammography, including Breast Ultrasound
- ☐ Pap Smear, including ThinPrep Pap Test
- ☐ PSA (Blood Test for Prostate Cancer)
- ☐ Serum Protein Electrophoresis (test for myeloma)
- ☐ Stress Test on Bike or Treadmill
- ☐ Thermography
- ☐ Ultrasound screening of abdominal aorta for abdominal aortic aneurysms
- ☐ COVID-19 PCR Testing

PHYSICIAN INFORMATION

Name:	Tax ID Number:	Phone Number:
Address, City, State, Zip:		