BANKERS
LIFE AND CASUALTY COMPANY
www.bankers.com

Policy Benefits Department
PO Box 1902
Carmel IN 46082-1902
Telephone: 1-800-621-3724

Dear Claimant:

This letter regards your inquiry into home care services to be provided by an Independent Caregiver.

Enclosed you will find the following forms that must be completed and returned to Bankers Life and Casualty Company for benefit eligibility consideration:

1. Claim Forms;
2. Independent Caregiver Form;
3. Independent Caregiver Acknowledgment of Terms and Release of Liability Form; and
4. Independent Caregiver Itemized Bill & Daily Visit Note Form for every date of service provided.

Once the above four documents are filled out completely and signed, return them with copies of proof of payment for the services provided by the Independent Caregiver. The following items are acceptable proof of payment:

1. bank statements showing cleared checks,
2. money orders,
3. original or copies of both the front and backs of cancelled checks,
4. electronic funds transfer statements, credit card transaction statements, or
5. payroll service statements.

Subject to the policy requirements for benefit eligibility, home health services provided by an Independent Caregiver, who is not employed by a home health care agency, will be considered subject to the following requirements:

1. He or she must be:
   a. a currently licensed Registered Nurse;
   b. a Licensed Practical Nurse;
   c. a Certified Nurse Aide; or
   d. included in a government sponsored Nurse Aide Registry.
2. We must receive a copy of the caregiver's current license or certification, or, if your policy permits, coverage may be considered for caregivers for whom we receive adequate proof of qualifying training or experience.

All forms must be fully completed, signed and dated. Any incomplete or missing forms may result in a claim processing delay. Please return all noted claim documents to:

Mailing Address	Fax Number
Bankers Life and Casualty Company Policy Benefits Department PO Box 1902, Carmel, IN 46082-1902	1-(312)-396-5952

Please call our Customer Service Representatives at 1-800-621-3724 with any questions between the hours of 8:00 a.m. and 4:30 p.m. Central Standard Time.

Sincerely,

Policyholder Service

Enclosures

BANKERS
LIFE AND CASUALTY COMPANY
www.bankers.com

INDEPENDENT CAREGIVER ACKNOWLEDGEMENT OF TERMS AND RELEASE OF LIABILITY FORM

POLICY NUMBER: _____

CLAIMANT NAME: _____

Please send completed claim form to:
Bankers Life and Casualty Company
PO Box 1902
Carmel IN 46082-1902

1. Any employer/employee relationship or contractual relationship concerning the provisions of care is strictly limited to you and the Independent Caregiver. Bankers Life and Casualty is not a party to this relationship.
2. Payment for services to the Independent Caregiver is entirely your responsibility, regardless of whether Bankers Life and Casualty is liable for reimbursement of the claim.
3. Any expenses you incur acting as an employer, which may include any payment of taxes you owe to state, local or federal government in addition to those amounts withheld from an employee's salary are your responsibility. Bankers Life and Casualty does not provide tax advice. Please contact your tax accountant or attorney with any employer tax questions.
4. You are obligated to abide by any local, state or federal laws and/or regulations applicable to this type of relationship.
5. You, as the employer or as the manager of the service contract, are solely responsible for the quality of care provided. Bankers Life and Casualty will have no liability regarding the acts or omissions of you or the Independent Caregiver.

We recommend you make copies of all documents you submit to Bankers Life and Casualty including weekly timesheets and proof of payment.

I have read and understand the above Independent Caregiver Acknowledgement of Terms and Release of Liability:

X _____ _____/_____/ _____
Signature of Claimant or Claimant's Representative — Date signed (Month/Day/Year)

_____ _____
Claimant or Claimant's Representative Name (Please Print) — Signed at (City, County, State)

_____
If Representative, give relationship to Claimant

_____ _____
Claimant Name — Policy Number

BANKERS
LIFE AND CASUALTY COMPANY
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INDEPENDENT CAREGIVER FORM

POLICY NUMBER: _____

CLAIMANT NAME: _____

Please send completed claim form to:
Bankers Life and Casualty Company
PO Box 1902
Carmel IN 46082-1902

Important: Each individual Independent Caregiver is required to complete this form.

Legal Name of Provider: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Cell Phone: (_____) _____

Hourly Rate: $ _____

Are you related to the Claimant by blood or marriage and/or do you normally live with the Claimant?

☐ Yes ☐ No If Yes, please explain relationship: _____

Start Date of Services for the Claimant: _____/_____/_____ End Date: _____/_____/_____

Step 1

Are you licensed or certified as one of the following?

☐ Yes, provide details below and proceed directly to Step 4.
☐ No, proceed to Step 2.

☐ Registered Nurse ☐ Licensed Vocational Nurse ☐ Licensed Practical Nurse
☐ Certified Home Health Aide ☐ Certified Nurse Aide ☐ Other Certificate/License

Provide license number: _____ State of issue for license: _____

Expiration Date: _____/_____/_____

Enclose a copy of current license or certification.

Step 2

Have you received formal training to provide home care services?

☐ Yes, provide details below and proceed directly to Step 4.
☐ No, proceed to Step 3.

List training course description and organization providing training:

Training Course Name: _____

Name of Organization Offering Training: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Contact Phone: (_____) _____

Enclose all documentation of proof of training.

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INDEPENDENT CAREGIVER FORM

POLICY NUMBER: _____

CLAIMANT NAME: _____

Please send completed claim form to:
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PO Box 1902
Carmel IN 46082-1902

Step 3

Do you have home care work experience?

☐ Yes, provide details below and proceed directly to Step 4.
☐ No

Employment Information:

☐ Employment as an aide at a hospital, skilled nursing facility, or licensed home agency

Name of Employer:_____

Employer Address: _____

Employer Contact Name:_____

Employer Contact Phone: (_____)_____

Please provide the following documents if you are an employee of a home care agency and do not have a current license or certification:

1. Proof of training courses completed and date of completion on company letterhead
2. List of experience you have with a current agency or prior employer
3. Letter(s) of reference

The following are not adequate evidence of training to provide home care services:

- C.P.R. certification
- First Aid course
- Medical Assistant

Step 4

Caregiver signature: _____ End Date:_____/ _____/_____

Print Name: _____

Claimant / Representative* signature: _____ End Date:_____/ _____/_____

Print Name: _____

* Enclose a copy of your legal authority

Note: Benefit payments cannot be assigned to an Independent Caregiver. Company supplied "Independent Caregiver Itemized Bill & Daily Visit Note" forms must be completed and submitted by all Independent Caregivers and must be freshly created for each date of service as care is provided.

Fraud Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties. Please refer to enclosed state variation sheet for state specific wording regarding the above fraud statement in the claim form packet.

Enclosures

AK residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

AR residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CA residents: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DC residents: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, the insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

DE residents: A person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

FL residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

ID residents: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN residents: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

KY residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LA and RI residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MD residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME / TN / VA and WA residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MN residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH residents: Any person who, with the purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. 638:20.

NJ residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY residents: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR residents: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PA residents: 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.

PR residents: Any person who, knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony, and upon conviction shall be sanctioned for each violation with the penalty of a fine of not *less* than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravated circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TX residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prision.

WV residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

All other states residents: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

INDEPENDENT CAREGIVER ITEMIZED BILL & DAILY VISIT NOTE FORM

BANKERS
LIFE AND CASUALTY COMPANY

CLAIMANT NAME (PRINT): _____ POLICY NUMBER: _____

CAREGIVER'S NAME (PRINT): _____ Check where services are rendered: ☐ Home ☐ Facility

Caregiver is a (check one): ☐ Certified Home Health Aide ☐ C.N.A. ☐ RN ☐ LPN/LVN ☐ Personal Care Attendant (PCA) ☐ Companion/Homemaker

The hired caregiver must complete this form in ink every visit. Return originals only. Retain a copy for your records. Under each date of service, please check services provided.

REQUIRED	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
DATE (Month/Day/Year)								
Arrival Time: AM/PM								
Departure Time: AM/PM								**Totals**
Total Hours Worked:								
Hourly Rate:	$	$	$	$	$	$	$	
Total Charge:	$	$	$	$	$	$	$	$
Services Provided:								
Ambulating Inside-Physically Assisted								
Ambulating Inside-Standby Assist								
Bathing-Physically Assisted								
Bathing-Standby Assist								
Bathing-Verbal Cue or reminder								
Dressing-Physically Assisted								
Dressing -Standby Assist								
Dressing- Verbal Cue or Reminder								
Eating-Spoon Fed or Tube Fed								
Eating-Verbal Cue or Reminder								
Transfer out of bed/chair-Physically Assist								
Transfer out of bed/chair-Standby Assist								
Transfer out bed/chair-Verbal Cue or Reminder								
Toileting-Physically Assisted								
Toileting-Standby Assist								
Toileting-Verbal Cue or Reminder								
Incontinent of bowel/bladder-Physically Assisted								
Assistance with Colostomy/Catheter Care								
Provided Continual Supervision due to Cognitive Impairment: **Cannot be left alone**								
Provided Continual Supervision due to a Physical Functional Incapacity: **Cannot be left alone**								
Companion Services								
Homemaking/Housekeeping-laundry, meal prep, dust, wash dishes, other:								

Was your client hospitalized or in a facility this week? ☐ Yes ☐ No

We cannot process this claim until this form is fully completed. Both signatures are required. The form should not be signed until the work week has concluded and all weekly services are recorded.

I hereby certify that the information provided above is a complete and accurate representation of the care provided and received.

Caregiver Signature: _____ Date: _____/_____/ _____

Claimant or Legal Representative Signature: _____ Date: _____/_____/ _____

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