Continental Casualty Company

ASSIGNMENT OF BENEFITS FORM

Instructions: *Please complete and sign this form if you and your provider have agreed to establish an Assignment of Benefits. You must first establish if the provider is willing to consider this Assignment of Benefits. The service provider will need to submit their Tax Identification Number (Social Security Number if service provider is an independent provider) and attach a completed W-9 form so the payments will be made directly to the service provider.*

The Assignment of Benefits will not be in effect until Continental Casualty Company has received the completed form. The Assignment of Benefits may be terminated in the future upon receipt of a written request stating you or the provider wishes to revoke the Assignment of Benefits.

You may return the completed form via fax to 952-983-5194 (preferred) or mail to: Continental Casualty Company, P.O. Box 64912, St. Paul, MN 55164-0912.

Claimant Name: _____

Policy Number: _____

I, _____ , the Claimant or the guardian or other legal Representative of the Claimant (legal documentation of guardianship or other representative capacity, if appropriate, is attached), hereby authorize direct payment to _____ (provider) of any long-term care benefits otherwise payable to or on behalf of the Claimant for the services provided at a rate not to exceed the Provider's regular charges. It is agreed that payment to the Provider, pursuant to this Assignment of Benefits, by the plan administrator shall discharge Continental Casualty Company of any and all obligation under the plan to the extent of such payments. It is understood by the undersigned that he/she is financially responsible for any charges not covered by this Assignment of Benefits. This Assignment of Benefits is valid for Continental Casualty Company.

_____ _____ *Service Provider Representative Signature* *Date* _____ *Printed Name of Service Provider Representative*	_____ _____ *Claimant/Legal Representative Signature* *Date* _____ *Printed Name of Claimant/Legal Representative** **If you are signing as a legal representative, describe the scope of your authority to act on the Claimant's behalf and include a copy of the documentation of your legal authority.*

Provider's Federal Tax ID Number/Social Security Number: _____

_____

Name of Service Provider

_____

Street Address City State Zip Code