LIFE INSURANCE COMPANY OF ALABAMA
P.O. BOX 349 GADSDEN AL 35902

CLAIMANT'S STATEMENT FOR ACCIDENT CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please complete the Authorization to Release Information and Medical Provider & Employer List. Please submit the completed forms to the above address along with the following information:

(1) A full copy of the Accident or Police Report and a copy of the Emergency Room Records (including alcohol and drug test results if testing was performed) is required for all Motor Vehicle Accidents.
(2) Attending Physician's Statement completed by the physician.
(3) A fully itemized statement of expenses from the Physician, Hospital or Emergency Room. Please include a copy of the Physician's records or a copy of the Admit and Discharge Summary (not the documents given to you when discharged).
(4) A fully itemized statement of expenses if you received services from any of the following providers:
   a) Ambulance Transportation
   b) X-rays (including the x ray report if there was a fracture or dislocation)
   c) Prosthetic device or appliance
(5) Medical certification is required for the entire period you are disabled.

POLICYHOLDER'S NAME _____ POLICY NUMBER(S) _____

ADDRESS _____

PHONE _____-_____-_____ SSN _____-_____-_____ DATE OF BIRTH _____-_____-_____

CHECK HERE IF NEW ADDRESS ☐ MALE ☐ FEMALE ☐

Employer's Name: _____ Employer's Phone: _____-_____-_____

Employer's Address: _____

Supervisor's Name: _____

THIS CLAIM IS ON: INSURED ☐ YOUR SPOUSE ☐ YOUR CHILD ☐ MALE ☐ FEMALE ☐

If the claim is on your spouse or child, please complete the following:

Patient's Name _____ SSN _____-_____-_____

Date of Birth _____-_____-_____ Relationship to Policyholder _____

What condition are you claiming? _____

What date did you first consult the Physician for this condition? _____-_____-_____

Primary Physician's Name: _____

Address: _____ Phone _____-_____-_____

1st Physician's Name _____

Address _____ Phone _____-_____-_____

2nd Physician's Name _____

Address _____ Phone _____-_____-_____

If you were hospitalized: Date Admitted _____-_____-_____ Date Discharged _____-_____-_____

Name of Hospital _____

Address of Hospital _____

Date Injured _____-_____-_____ Time of Accident _____ Where did accident happen? _____

Did the accident happen while working on-the-job? Yes ☐ No ☐

Tell us exactly how the accident happened. _____

_____

IMPORTANT NOTICE: 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.

I certify the above information is true to the best of my knowledge.

_____ _____-_____-_____

Signature Date