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

CLAIMANT'S STATEMENT FOR CANCER 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 Pathology Report first diagnosing malignant cancer.
(2) Attending Physician's Statement completed by the physician.
(3) A fully itemized statement of expenses from all providers for the definitive treatment of cancer (for example: hospital, surgeon, anesthesia, chemotherapy, radiation). The statements should include CPT (current procedural terminology) codes, billed amounts, payments, and credits for each service.
(4) An Explanation of Benefits from your primary insurance company for each service.

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 type of cancer were you diagnosed with? _____

What date were you diagnosed with cancer? _____-_____-_____

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

Prior to this diagnosis, have you ever been diagnosed with a malignant cancerous condition? Yes☐ No☐
If yes, when were you diagnosed? _____-_____-_____ What type of Cancer? _____

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 _____

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