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

# CLAIMANT'S STATEMENT FOR HEART 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:

If you are claiming benefits under the Heart Attack provision of the policy, please submit the following:

(1) Cardiac Enzyme (CKMB, Troponin) tests results.
(2) EKG test results.
(3) Copy of the hospital Admit and Discharge Summary (not the documents given to you when discharged).
(4) Attending Physician's Statement completed by the cardiologist.

If you are claiming benefits under the Major Heart Surgery provision of the policy, please submit the following:

(1) Operative Report
(2) Copy of the hospital Admit and Discharge Summary (not the documents given to you when discharged).
(3) Attending Physician's Statement completed by the cardiologist.

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: _____

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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 _____

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What condition are you claiming? ☐Heart Attack ☐Major Heart Surgery

What date were you diagnosed with this condition? _____-_____-_____

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 _____

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***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