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

CLAIMANT'S STATEMENT FOR KIDNEY FAILURE or MAJOR ORGAN TRANSPLANT 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 for Kidney Failure, please send us the following information.

(1) CT scan, MRI or similar imaging diagnosing Kidney Failure.
(2) Clinical evidence of Kidney Failure.
(3) Results of lab testing (biopsy, urine tests, blood tests) which indicate Kidney Failure.
(4) Operative Report for the Kidney Transplant
(5) Copy of the hospital Admit and Discharge Summary (not the documents given to you when discharged).
(6) Attending Physician's Statement completed by the Physician.

If you are claiming benefits for Major Organ Transplant, please send us the following information.

(1) Operative Report for the Major Organ Transplant
(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 Physician.

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 date were you diagnosed with Kidney Failure? _____-_____-_____

What date did you first consult the Physician for Kidney Failure? _____-_____-_____

When did you begin Kidney or Peritoneal Dialysis? _____-_____-_____

When did you receive a Major Organ Transplant? _____-_____-_____

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