

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604

Phone: (800) 366-8354

Fax: (580)-255-0951

CANCER SCREENING BENEFIT CLAIM FORM

Policy Number	Name of Patient	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Name and Address of Primary Insured		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
		Social Security No.	Telephone ()
Spouse's Name			
Patient is:	<input type="checkbox"/> Primary Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> *Other Child	<input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student (Where?)
* (If "Other" please explain):			
Home Address of Patient:			
Address	City or Town	State(or Province)	Zip Code
INSTRUCTIONS			
ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE AND AMOUNT CHARGED. FOR ASSISTANCE, CALL TOLL FREE 1-800-366-8354.			
Warning: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.			
I further certify that I have read and understand the above Fraud Warning Statement and the additional Fraud Warning			
Signature of Claimant	Present Address:	Date:	

Early Detection Form