LOYAL AMERICAN LIFE INSURANCE COMPANY®
PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604
Phone (800) 366-8354

INSTRUCTIONS FOR FILING A MEDICAL CLAIM CANCER TREATMENT

The forms must be completed by the claimant. All questions on the forms must be answered in full. Incomplete or illegible answers may result in the delay of claim consideration. Please return the requested information as soon as possible for prompt processing.

The claimant is responsible for this information without expense to the Company.

- The enclosed **Statement of Claim** should be fully completed by the primary insured and the patient. Please make sure the Authorization at the bottom of the page is signed and dated.
- The **Physician's Statement of Claim** should be completed by your primary treating physician.
- A **Pathology Report** showing a positive diagnosis of Cancer and the date it was made. This can be obtained from the physician.
- **Itemized Hospital Bills:** Please obtain from the hospital or outpatient facility the UB04 standard billing form or a detailed billing indicating line by line description of services and diagnosis.
- **Itemized Physician Bills:** Please obtain a HCFA1500 from the physicians for surgery, anesthesiology, and chemotherapy, radiation therapy. Itemized billings which provide us with the diagnosis, procedure codes, charges and service dates are also acceptable.
- **Primary Insurance EOBs:** If you have a primary insurance carrier which has paid on your claim, please include their explanation of benefits.
- The enclosed **HIPAA** form, Authorization Form for Disclosures of a Claimant's
- Protected Health Information should be fully completed by the **patient.**
- The enclosed **Personal Representative HIPAA** form, Authorization Form for
- Disclosures of a Claimant's Protected Health Information to Personal Representative should be completed if someone other than the patient needs to be able to discuss sensitive policy or claim information with our office. The patient may also provide a copy of a current **General Durable Power of Attorney** in lieu of this form.
- Please **DO NOT HIGHLIGHT** your bills or forms.

If your condition was diagnosed within the first two (2) years of your policy's effective date, it is considered contestable. We may request medical records from the physicians who have treated you within the five (5) years prior to the policy effective date. Please make sure to provide a list of the full names, addresses and telephone numbers of all physicians who have treated you.

This instruction form and our requests for additional information should not be considered a guarantee that payment will be made. Please make sure all documentation requested is fully completed and returned to our office as soon as possible. If you have questions, please contact our Customer Service Department.

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Statement of Claim - Individual Policy

Section 1 - To be completed by the Insured (Complete all applicable sections)

Insured's name:	Phone: ( )	☐ Check here if your address has changed	Policy/Certificate No. MPOLICY
Insured's address:		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Insured's date of birth:	Social Security No.:	Employer's name & address:	
Claim is for: ☐ Self ☐ Child ☐ Spouse	Claimant's name and SSN (if not insured):	Sex of claimant: ☐ Male ☐ Female	Claimant's date of birth:
If dependent child is over age 19, indicate: ☐ Handicapped ☐ Student	If full time student, give name and address of school:	Claimant's occupation:	

Do you, your spouse, whether married or divorced, or any of your dependent children have any other medical insurance coverage? Answer each question.

Name and address of insured person:	Name and address of insurance co.:	Policy No.:_____ Soc. Sec. No.:_____ Certificate No.:_____ Effective Date:_____

This claim is due to: ☐ Heart Attack ☐ Heart Disease ☐ Dread Disease ☐ Cancer
☐ Stroke ☐ Heart Surgery ☐ Other (Please Specify):

Nature of Illness:	Date of First Symptoms:	List full name, address and phone # of your Primary Care Physician:

List name and full address of all Hospitals where you were treated for this condition.

List Full name and address of any other medical providers who have treated you and their specialty:

Name:	Address:	Phone#	Specialty	Date

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INSTRUCTIONS

Forms must be completed by the Claimant or Claimant's Representative. If completed by a Representative, the attached AUTHORIZATION FORM FOR DISCLOSURES OF AN INSURED'S PROTECTED HEALTH INFORMATION TO A DESIGNATED PERSONAL REPRESENTATIVE(S) needs to be completed or you may send a General Durable Power of Attorney. All questions on this and other enclosed forms must be answered in full. Incomplete or illegible answers may result in the delay of claim consideration. Please be sure to sign the attached AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION. Please return the forms along with the Clinical Documentation on which the doctor based the diagnosis of the condition for which you are applying for benefits. If there are additional instructions attached, please be sure to read them carefully and provide us with all information requested.

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 Statements that appear on the back of this page that might apply to me or my family.

_____

Signature of Claimant Present Address Date

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ATTENDING PHYSICIAN'S STATEMENT OF CLAIM		
TO BE FULLY COMPLETED BY YOUR PRIMARY TREATING PHYSICIAN.		
PATIENT'S NAME (First, MI, Last)	PATIENT'S DATE OF BIRTH	INSURED'S NAME (First, mi, last)
INSURED'S SOCIAL SECURITY #	PATIENT'S SEX ☐ Male ☐ Female	INSURED'S ID or MEDICARE # (include any letters)
PATIENT'S ADDRESS (Street, city, state, zip)	INSURED'S POLICY # MPOLICY	
DATE FIRST CONSULTED FOR THIS CONDITION:	DATE LAST TREATED:	WAS PATIENT TREATED BY ANOTHER PHYSICAN(S), PRIOR TO YOUR TREATMENT ☐ YES ☐ NO
IF YES PROVIDE NAME AND ADDRESS OF PHYSICIAN'S KNOWN:		
DATE SYMPTOMS FIRST APPEARED	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS ☐ YES ☐ NO	
IF 'YES', PROVIDE DETAILS INCLUDING DATES OF TREATMENT AND DIAGNOSIS		
IF YOU REFERRED PATIENT TO ANOTHER PHYSICIAN, PLEASE PROVIDE NAME , ADDRESS OF PHYSICIAN, DATE OF REFERRAL:		
IS CONDITION DUE TO AN ACCIDENT? ☐ YES ☐ NO	IF YES, HOW DID ACCIDENT HAPPEN?	
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if not home or office)		
DID YOU ORDER HOSPITAL CONFINEMENT ☐ YES ☐ NO DATE ADMITTED: _____ DATE DISCHARGED: _____	FOR SERVICES RELATED TO HOSPITALIZATION, NAME & ADDRESS OF FACILITY	
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		
1.		
2.		
3.		
20. SIGNATURE OF PHYSICIAN OR SUPPLIER	21. YOUR SSN	22. PHYSICIAN'S/SUPPLIER'S NAME, ADDRESS, PHONE #
DATE	23. YOUR TAX ID #	

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AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. I authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to the Company's claims and underwriting representatives by and through the Company's contracted agent, LabOne.
2. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.
3. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 1604, Duncan, Oklahoma 73534-1604.
4. This authorization will expire twenty-four (24) months from the date the authorization is signed.
5. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitlement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment of benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.
8. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

If you are the representative of the claimant, describe the scope of your authority to act on the claimant's behalf:

_____

_____

Claimant
Name_____

Name and relationship of claimant's Personal representative, if applicable

_____

Signature of claimant (or claimant's representative)

_____

Date of claimant's (or claimant's representative)
signature_____

A signed copy of this form will be provided any time upon request.

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AUTHORIZATION FORM FOR DISCLOSURES OF AN INSURED'S PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONAL REPRESENTATIVE(S)

I hereby authorize the use or disclosure of protected health information about me by Loyal American Life Insurance Company (hereinafter "the Company") as described below.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

Name	Address	Relationship	Date of Birth	Social Security #

Describe fully the protected health information that is NOT allowed to be disclosed to the above named personal representative(s).

_____

_____

I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the Notice of Privacy Practices of the Company, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Officer at P.O. Box 1604, Duncan, Oklahoma, 73534-1604.

This authorization will expire upon the earliest of the following:
This date: _____; or twenty-four (24) months from the date the authorization is signed.

I understand that I am not required to sign this authorization form and that the Company will not condition the provision of payment to me on the signing of this authorization. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

_____ _____
Insured Name Personal Representative (if applicable)

_____ _____
Signature of Insured or Representative Relationship of Representative to Insured

_____ _____
Date of Signature Insured's Policy Number

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Transportation Verification Form

Policy Number _____ Name of Patient _____ ☐ Male ☐ Female Date of Birth _____

Name and Address of Primary Insured ☐ Male ☐ Female Date of Birth _____

Social Security No. _____ Telephone ( )

Spouse's Name _____

Travel by: ☐ Airline ☐ Railroad ☐ Bus ☐ Private Automobile
(Attach copy of airline, railroad or bus ticket)

I hereby certify that _____ traveled to or from a hospital for the treatment of cancer
(patient's name)
on the following dates:

DATE	MILEAGE	FROM	TO
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DIAGNOSIS: _____

TYPE OF TREATMENT RECEIVED: _____

_____

Was this treatment available in the city where the patient resides? ☐ Yes ☐ No

If not, where is the nearest hospital where the treatment could have been rendered?

City and State: _____

Signed: **X**_____ Date: _____
Physician's Signature

Printed: _____
Name, Address and Telephone Number

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 the above Fraud Warning Statement and the additional Fraud Warning Statements that appear on the back of this page that might apply to me or my family.

X _____ Date: _____
Insured's Signature

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FRAUD WARNING STATEMENTS

The law in **ALASKA** states: "A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony."

For your protection the law in **ARIZONA** states:" Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal penalties."

The law in **ARKANSAS** states:" Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

For your protection the law in **CALIFORNIA** states: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

The law in **COLORADO** states: "It Is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance companywhoknowinglyprovidesfalse,incomplete,ormisleadingfactsorinformationtoapolicyholderorclaimantforthepurposeofdefraudingorattemptingtodefraudthepolicyholderorclaimantwhregardtoasettlementorawardpaymentfrominsuranceproceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DELAWARE** states: "A person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree."

The law in **IDAHO** states: "Any person who knowingly, and with intent to defraud or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading, information is guilty of a felony."

The law in **INDIANA** states:" A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

The law in **KENTUCKY** states: "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."

The law in **LOUISIANA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in **MAINE** states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits."

The law in **MINNESOTA** states: "A person, who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, is guilty of a crime."

The law in **NEWJERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in **NEW MEXICO** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines a and criminal penalties."

The law in **OHIO** states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in **OKLAHOMA** states: "**WARNING**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in **PENNSYLVANIA** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties."

The law in **TEXAS** states: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

The law in **VIRGINIA** states: "Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law."