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

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.
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 Date Present Address