All American Associates

CANCER SCREENING WELLNESS CLAIM

To: All American Associates **From:** _____

Fax: 785-228-1720 **Date:** _____

Pages: _____ **Phone:** _____

INSTRUCTIONS

ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE AND CHARGE. FOR ASSISTANCE, CALL TOLL FREE: *1-800-715-1702*

Policy Number _____ Name of Patient _____

Date of Birth _____ Male ❑ Female ❑ Student ❑ *Where?* _____

Name and Address of Primary Insured Social Security No.: _____

_____

_____

_____

_____

Patient is: ❑ Primary Insured

❑ Spouse

❑ Child

❑ Other: _____

LOYAL AMERICAN LIFE INSURANCE COMPANY