

**LOYAL AMERICAN LIFE INSURANCE COMPANY®**

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604

Phone (800) 366-8354

**Transportation Verification Form**

Policy Number _____	Date of Birth _____	Name of Patient _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name and Address of Primary Insured _____ _____			
<input type="checkbox"/> Male <input type="checkbox"/> 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:

<u>DATE</u>	<u>MILEAGE</u>	<u>FROM</u>	<u>TO</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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