Philadelphia American Life Insurance Company
PO Box 34952 Omaha, NE 68134-9832

CANCER SCREENING REIMBURSEMENT CLAIM FORM (C16)

Routine cancer screenings can play an important role in achieving and maintaining a healthy lifestyle. Early detection of cancer often leads to additional treatment options and a greater chance of fighting this disease. Because we care about you and know the importance of these screenings, we have made the claim filing process easy for you!

If you have one of the covered screening tests listed below, simply complete this claim form and then fax or mail it to us and we'll promptly review your claim for benefits! No copy of the bill is required as we can verify the test directly with your physician. Please complete a separate claim form for each family member. You may fax this form to us toll-free at 1-888-453-5127. Or if you prefer, you can mail it to us at the above address.

If you have any questions, please feel free to call and speak to any one of our Customer Service Representatives at 1-800-541-2363, extension 6001, from 7:30 a.m. to 5:00 p.m. Central Standard Time.

To Be Completed By Insured

Insured's Name: _____ PALIC Policy Number: _____

Insured's Address: _____

Claimant's Name: _____ Claimant's Date of Birth: _____

Relationship to Insured: _____ Date of Test: _____

Name of Physician: _____ Physician's Phone Number: _____

Physician's Address: _____

*Your PALIC Cancer policy provides a scheduled benefit amount based on the type of test performed. The maximum amount payable is $100 per calendar year per insured person for any one or more of the screening tests listed below. Your policy has a 60 day waiting period following the effective date when cancer screening tests are not payable. Please refer to your policy for benefits and limitations. *Policies issued in CA have separate annual benefits for mammography and cervical cancer screening. The mammography benefit is $75 and the cervical cancer screening benefit is $25. If you have a CA policy, please refer to your policy for details.*

Please check the Cancer Screening Test(s) received by you or a covered family member on the above date.

( ) Mammography/breast ultrasound $75*
( ) Cervical cancer screening $25*
( ) CA 125 (blood test for ovarian Cancer) $50
( ) PSA (blood test for prostate Cancer) $50
( ) Hemocult stool specimen $10
( ) CA 15-3 (blood test for breast Cancer) $50
( ) Flexible sigmoidoscopy $100
( ) CEA (blood test for colon Cancer) $50
( ) Colonoscopy $100
( ) Chest X-ray $50
( ) Thermography $50
( ) Serum protein electrophoresis $25
( ) Biopsy for Skin Cancer $50

I certify that the above statements are true and correct and hereby authorize any physician or other health care provider to give PALIC any additional information needed in connection with this claim. If a special authorization is required by my physician to confirm the above information, I will promptly complete any authorization requested of me and return to PALIC.

Date: _____ Claimant's Signature: _____
Or Parent/Guardian If Claimant Is A Minor

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.