PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®
P.O. Box 34952 • Omaha, NE 68134-9832

AGCY BEN

Claim Form

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.

INSTRUCTIONS:
1. Please make sure all questions are complete on this form.
2. If we request an authorization form from you, please complete, sign and date the authorization forms we've included. Please keep one copy of the authorization for your records and return the other copy to us along with the completed claim form.
3. Please attach itemized hospital bills, physician bills, and other documentation of expenses.

Insured's full name _____ Policy number _____

Address _____ Daytime telephone no. _____
STREET CITY STATE ZIP CODE

Claimant's full name _____ Date of birth _____ Relation to insured _____
MO DAY YEAR

☐ Check if this is a new address _____

Type of coverage you are filing claim under: ☐ **Cancer/specified disease** ☐ **Intensive Care** ☐ **Critical Illness** ☐ **Other**

If sickness 1. a. Condition claim is being filed for:	a. _____
b. Date symptoms first noticed.	b. Date _____
c. Date first saw doctor for symptoms.	c. Date _____ Still being treated? ☐ Yes ☐ No
d. Name and address of first doctor seen.	d. _____
e. Name and address of other doctors seen.	e. _____
f. Has patient ever had this or similar condition before? If yes, give details.	f. ☐ Yes ☐ No Date _____
If accident 2. a. Explain the injuries and how the accident happened.	a. _____
b. Give the date of the accident.	b. Date _____
c. Name and address of treating physician:	c. _____
3. Has patient had other medical treatment during past five years? (Describe conditions, name doctors consulted, give their addresses, and give dates seen.)	☐ Yes ☐ No _____
4. List the name and address of your regular or family physician:	_____
5. Was patient hospitalized? If yes, give dates, name and address of hospital.	☐ Yes ☐ No _____ (HOSPITAL) (CITY) (STATE) Admitted Date _____ ☐ AM ☐ PM Discharge Date _____ ☐ AM ☐ PM
6. a. If you are the primary insured, are you unable to work due to cancer/specified disease?	a. ☐ Yes ☐ No
b. Date first unable to work.	b. Date _____
c. Have you returned to work?	c. ☐ Yes ☐ No Date _____

I certify that the above statements are true and correct.

Date _____ Insured's Signature _____

Form 3582

For claim questions call toll free 1-800-554-0092

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