INSTRUCTIONS FOR FILING A MEDICAL CLAIM CANCER TREATMENT

The forms must be completed by the claimant. All questions on the forms must be answered in full. Incomplete or illegible answers may result in the delay of claim consideration. Please return the requested information as soon as possible for prompt processing.

The claimant is responsible for this information without expense to the Company.

- The enclosed Statement of Claim should be fully completed by the primary insured and the patient. Please make sure the Authorization at the bottom of the page is signed and dated.
- The Physician's Statement of Claim should be completed by your primary treating physician.
- A Pathology Report showing a positive diagnosis of Cancer and the date it was made. This can be obtained from the physician.
- Itemized Hospital Bills: Please obtain from the hospital or outpatient facility the UB04 standard billing form, or a detailed billing indicating line by line description of services and diagnosis.
- Itemized Physician Bills: Please obtain a HCFA1500 from the physicians for surgery, anesthesiology, chemotherapy and radiation therapy. Itemized billings which provide us with the diagnosis, procedure codes, charges and service dates are also acceptable.
- Primary Insurance EOBs: If you have a primary insurance carrier which has paid on your claim, please include their explanation of benefits.
- The enclosed HIPAA form, Authorization Form for Disclosures of a Claimant's Protected Health Information should be fully completed by the patient.
- The enclosed Personal Representative HIPAA form, Authorization Form for Disclosures of a Claimant's Protected Health Information to Personal Representative should be completed if someone other than the patient needs to be able to discuss sensitive policy or claim information with our office. The patient may also provide a copy of a current General Durable Power of Attorney in lieu of this form.
- Please DO NOT HIGHLIGHT your bills or forms.

***If you send receipts, please send photocopies. It is possible for a claim to be lost or damaged in the mail, and if the originals are sent you more than likely will not be able to get another copy.

If your condition was diagnosed within the first two (2) years of your policy's effective date, it is considered contestable. We may request medical records from the physicians who have treated you within the five (5) years prior to the policy effective date. Please make sure to provide a list of the full names, addresses and telephone numbers of all physicians who have treated you.

This instruction form and our requests for additional information should not be considered a guarantee that payment will be made. Please make sure all documentation requested is fully completed and returned to our office as soon as possible. If you have questions, please contact our Customer Service Department.
## Statement of Claim - Individual Policy

### Section 1 - To be completed by the Insured (Complete all applicable sections)

<table>
<thead>
<tr>
<th>Insured’s name:</th>
<th>Phone: ( )</th>
<th>Check here if your address has changed</th>
<th>Policy/Certificate No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured’s address:</td>
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<td>Marital Status:</td>
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<td></td>
<td></td>
<td>Single</td>
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<td>Married</td>
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<td>Divorced</td>
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<td></td>
<td>Widowed</td>
</tr>
<tr>
<td>Insured’s date of birth:</td>
<td>Social Security No.:</td>
<td>Employer’s name &amp; address:</td>
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</tbody>
</table>

### Claim is for:
- [ ] Self
- [ ] Child
- [ ] Spouse
- [ ] Not Insured

### 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:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
<th>Phone#:</th>
<th>Specialty</th>
<th>Date</th>
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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  Present Address  Date
# Loyal American Life Insurance Company

**Universal Fidelity Life Insurance Company as Administrator**

**PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604, Toll-Free (800) 366-8354, Fax 580-255-0951**

## Attending Physician's Statement of Claim

**To be fully completed by your primary treating physician.**

<table>
<thead>
<tr>
<th>Patient's Name (First, Mi, Last)</th>
<th>Patient's Date of Birth</th>
<th>Insured's Name (First, mi, last)</th>
</tr>
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<tbody>
<tr>
<td>Insured's Social Security #</td>
<td>Patient's Sex</td>
<td>Insured's ID or Medicare #</td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td>(include any letters)</td>
</tr>
<tr>
<td>Patient's Address (Street, city, state, zip)</td>
<td>Insured's Policy #</td>
<td></td>
</tr>
</tbody>
</table>

**Date First Consulted For This Condition:**

**Date Last Treated:**

**Was Patient Treated by Another Physician(s), Prior To Your Treatment**

- [ ] Yes
- [ ] No

**If Yes, Provide Name and Address of Physician's Known:**

<table>
<thead>
<tr>
<th>Date Symptoms First Appeared</th>
<th>Has Patient Ever Had Same or Similar Symptoms</th>
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<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

**If 'Yes', Provide Details Including Dates of Treatment and Diagnosis**

**If you referred patient to another physician, please provide name, address of physician, date of referral:**

**Is Condition Due To An Accident?**

- [ ] Yes
- [ ] No

**If Yes, How Did Accident Happen?**

**Name & Address of Facility Where Services Rendered (if not home or office):**

<table>
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<tr>
<th>Did You Order Hospital Confinement</th>
<th>Yes</th>
<th>No</th>
<th>For Services Related to Hospitalization, Name &amp; Address of Facility</th>
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<td>Date Admitted:</td>
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<tr>
<td>Date Discharged:</td>
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**19. Diagnosis or Nature of Illness or Injury**

1.  
2.  
3.  

**20. Signature of Physician or Supplier**

**21. Your SSN**

**22. Physician's/Supplier's Name, Address, Phone #**

**Date**

**23. Your Tax ID #:**
LOYAL AMERICAN LIFE INSURANCE COMPANY®
Universal Fidelity Life Insurance Company as Administrator
PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604, Toll-Free (800) 366-8354, Fax 580-255-0951

AUTHORIZATION FORM FOR DISCLOSURES OF A CLAIMANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. I authorize all health care providers who have provided treatment or other health care services to me to disclose all information regarding my treatment to the Company's claims and underwriting representatives by and through the Company's contracted agent, LabOne.

2. The information which is described above will be disclosed to the Company to determine my entitlement to benefits under my health benefits plan or policy.

3. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Claims Department at P.O. Box 1604, Duncan, Oklahoma 73534-1604.

4. This authorization will expire twenty-four (24) months from the date the authorization is signed.

5. I understand that the information which will be provided under this authorization is necessary for the Company to evaluate my entitlement to benefits under my health benefits plan or policy and that the Company will condition the provision of payment of benefits to me on my providing this authorization, and my claim may be denied if I refuse to provide this authorization.

6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations.

7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.

8. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

If you are the representative of the claimant, describe the scope of your authority to act on the claimant's behalf:

________________________________________________________________________

Claimant
Name__________________________________________________________

Name and relationship of claimant's Personal representative, if applicable

________________________________________________________________________

Signature of claimant (or claimant's representative)

________________________________________________________________________

Date of claimant's (or claimant's representative) signature________________________________________

A signed copy of this form will be provided any time upon request.
I hereby authorize the use or disclosure of protected health information about me by Loyal American Life Insurance Company (hereinafter "the Company") as described below.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Social Security #</th>
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Describe fully the protected health information that is NOT allowed to be disclosed to the above named personal representative(s).

____________________________________________________________________________________

I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the Notice of Privacy Practices of the Company, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company’s Privacy Officer at P.O. Box 1604, Duncan, Oklahoma, 73534-1604.

This authorization will expire upon the earliest of the following:
This date: ___________; or twenty-four (24) months from the date the authorization is signed.

I understand that I am not required to sign this authorization form and that the Company will not condition the provision of payment to me on the signing of this authorization. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

Insured Name ___________________________________________  Personal Representative (if applicable) __________________________

Signature of Insured or Representative ___________________________  Relationship of Representative to Insured __________________________

Date of Signature ___________________________________________  Insured’s Policy Number __________________________
LOYAL AMERICAN LIFE INSURANCE COMPANY®
Universal Fidelity Life Insurance Company as Administrator
PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604, Toll-Free (800) 366-8354, Fax 580-255-0951

Transportation Verification Form

Policy Number ____________________________ Name of Patient ____________________________
Male □ Female □ Date of Birth ____________

Name and Address of Primary Insured ____________________________
Male □ 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
on the following dates:

<table>
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<tr>
<th>DATE</th>
<th>MILEAGE</th>
<th>FROM</th>
<th>TO</th>
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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 ____________________________
Physician’s Signature ____________________________ Date: ____________________________

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 ____________________________

FRAUD WARNING STATEMENTS
The law in **ALASKA** states: "A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony."

For your protection the law in **ARIZONA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal penalties."

The law in **ARKANSAS** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

For your protection the law in **CALIFORNIA** states: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

The law in **COLORADO** states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant in regard to a settlement or award payment from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DELAWARE** states: "A person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **IDAHO** states: "Any person who knowingly, and with intent to defraud or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading, information is guilty of a felony."

The law in **INDIANA** states: "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in **LOUISIANA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in **MAINE** states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits."

The law in **MINNESOTA** states: "A person, who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, is guilty of a crime."

The law in **NEW JERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in **NEW MEXICO** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines a and criminal penalties."

The law in **OHIO** states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in **OKLAHOMA** states: "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."

The law in **PENNSYLVANIA** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in **TEXAS** states: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

The law in **VIRGINIA** states: "Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law."