Loyal American Insurance Company ®

PO Box 1604, Duncan, Oklahoma, 73534-1604
Phone (800) 366-8354
Fax (580) 255-0951

Cancer Screening Benefit Claim 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:			

Patient is:			
☐ Primary Insured	☐ Spouse	☐ Married	☐ Employed
☐ Natural Child	☐ Step-Child	☐ Unmarried	☐ Unemployed
☐ Adopted Child	☐ *Other Child	☐ Divorced	☐ Student (Where)
		☐ Legally Separated	

* (If "Other" please explain):

Home Address of Patient:

Address	City or Town	State	Zip Code

INSTRUCTIONS

ATTACH A COPY OF THE DOCTORS BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE AND AMOUNT CHARGED. FOR ASSISTANCE, CALL TOLL FREE 1-800-366-8354.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of a insurance policy containing 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

Signature of Claimant	Present Address	Date