

CLAIMANT'S STATEMENT FOR DREAD DISEASE CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please complete the Authorization to Release Information and Medical Provider & Employer List. Please submit the completed forms to the above address along with the following information:

- (1) Cytology and/or other laboratory, imaging reports or diagnostic testing diagnosing the condition.
- (2) Attending Physician's Statement completed by the physician.
- (3) A fully itemized statement of expenses showing CPT procedure codes, billed amounts, payments, and credits from the Hospital. Please include a copy of the Admit and Discharge Summary (not the documents given to you when discharged).

POLICYHOLDER'S NAME _____ POLICY NUMBER(S) _____
ADDRESS _____
PHONE _____ - _____ - _____ SSN _____ - _____ - _____ DATE OF BIRTH _____ - _____ - _____
CHECK HERE IF NEW ADDRESS MALE FEMALE
Employer's Name: _____ Employer's Phone: _____ - _____ - _____
Employer's Address: _____
Supervisor's Name: _____

THIS CLAIM IS ON: INSURED YOUR SPOUSE YOUR CHILD MALE FEMALE

If the claim is on your spouse or child, please complete the following:

Patient's Name _____ SSN _____ - _____ - _____
Date of Birth _____ - _____ - _____ Relationship to Policyholder _____

What condition are you claiming? _____

What date were you diagnosed with this condition? _____ - _____ - _____

What date did you first consult the Physician for this condition? _____ - _____ - _____

Primary Physician's Name: _____

Address: _____ Phone _____ - _____ - _____

1st Physician's Name _____

Address _____ Phone _____ - _____ - _____

2nd Physician's Name _____

Address _____ Phone _____ - _____ - _____

If you were hospitalized: Date Admitted _____ - _____ - _____ Date Discharged _____ - _____ - _____

Name of Hospital _____

Address of Hospital _____

IMPORTANT NOTICE: 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.

I certify the above information is true to the best of my knowledge.

Signature

Date