AMERICAN INCOME LIFE INSURANCE COMPANY

P.O. Box 2608 Waco, Texas 76797
(254) 761-6400 www.ailife.com

1. **Claim Form Must Be Completed By INSURED and Doctor.**
2. **Attach a copy of the pathology report that first diagnosed cancer.**
3. **Mail With The Claim Form All Itemized Doctor and Hospital Bills.**
4. **Mail The Form In Yourself. Do Not Leave It For The Doctor to Mail.**

PART A CLAIMANT'S STATEMENT - TO BE COMPLETED ON ALL CLAIMS

Policy Numbers			
Policyowner's Name		Policyowner's Address	
Policyowner's union and local		Policyowner's occupation/Employer	
Patient's name		Names of other insurance companies which cover this claim	
Patient's birthdate	Relation to policyowner		

List the names and addresses of doctors consulted for this accident or sickness and dates of treatment.

DOCTOR	ADDRESS	DATES

If hospitalized, name and address of hospitals and dates of confinement.

HOSPITAL	ADDRESS	DATES

Date that symptoms first appeared	Date of first treatment by doctor	
Nature of sickness or accident	If an accident, how did it happen?	Date of accident
Have you ever had symptoms of this condition before? ☐ Yes ☐ No When?		
Date required to give up work	Date returned to work	

List all sickness or injuries for which treatment was required in the past five years.

CONDITION DATE	CONDITION DATE	CONDITION DATE

For your protection, laws in certain jurisdictions require the following to appear on this form.

Any person who knowingly presents a false or fraudulent claim form for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 and subjects such person to criminal and civil penalties.

Claimant's Signature **X** _____

E-mail address _____

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

Patient's Signature **X** _____ Date _____

Patient's Address _____ Phone # _____

PLEASE INCLUDE A COPY OF THE PATHOLOGY REPORT THAT FIRST DIAGNOSED CANCER.

PART B **ATTENDING PHYSICIAN'S STATEMENT**

Patient's name	Patient's address
Patient's date of birth	
Diagnosis and Concurrent Conditions: (if diagnosis code other than International Classification of Diseases, give name)	Does condition arise out of patient's employment? ☐ Yes ☐ No
	If condition due to pregnancy, date pregnancy commenced

Report of Services (or attach itemized bill)			Procedural Code (Give name if not Current Procedural Terminology	Charges
Date of Services	Place of Services	Description of Surgical or Medical Services		
			TOTAL CHARGES	

If hospitalized, name and address of hospitals and dates of confinement.

HOSPITAL	ADDRESS	DATES

Date symptoms first appeared	Result of an accident? ☐ Yes ☐ No
Date patient first consulted you for this condition	Patient still under your care for this condition? ☐ Yes ☐ No
Patient ever had same or similar condition? ☐ Yes ☐ No If yes, when?	Describe same or similar condition
Patient was continuously TOTALLY DISABLED (unable to work) FROM TO	Patient was PARTIALLY DISABLED FROM TO
If still disabled, date patient should be able to return to work	Does patient have other health coverage? ☐ Yes ☐ No

Name of other health coverage

Physician's Name (please print) _____

Physician's Address _____

Date _____ Phone # _____ Signature of Physician **X** _____

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