Loyal American
Life Insurance Company®

Wellness Claim

To: _____ **From:** _____

Fax: 816-841-3790 **Date:** _____

Pages: _____ **Phone:** _____

INSTRUCTIONS

ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE AND CHARGE. FOR ASSISTANCE, CALL TOLL FREE 1-800-366-8354.

Policy Number_____ Name of Patient_____

Date of Birth_____ Male ❑ Female ❑ Student ❑ Where? _____

Name and Address of Primary Insured

_____

_____

_____

Patient is:

❑ Primary Insured

❑ Spouse

❑ Child

❑ Other _____