INSTRUCTIONS FOR FILING A FIRST OCCURRENCE CLAIM
DREAD DISEASE/CRITICAL ILLNESS

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.

- A **Clinical Report** on which the doctor based the diagnosis of one of the Dread Diseases/Critical Illnesses as described in the rider attached to the policy.
- The enclosed **Statement of Claim – Individual Policy** should be fully completed by the primary insured and the patient. Please make sure the Certification at the bottom of the page is signed and dated
- The **Physician's Statement of Claim** should be completed by your primary treating physician.
- 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.

As soon as the completed forms and pathology report are received in our office, we will begin processing this claim. This may include **our** obtaining Medical Records from the listed medical providers. Once we receive and review the Medical Records, the claim will be processed according to policy provisions.

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 as soon as possible. If you have questions, please contact our Customer Service Department.

DDR

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604

Phone (800) 366-8354

Statement of Claim - Individual Policy

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

Insured's name:	Insured's address: Phone: ( )	☐ Check here if your address has changed	Policy/Certificate No.

Insured's date of birth:	Social Security No.:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Employer's name & address:

Claim is for: ☐ Self ☐ Child ☐ Spouse	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 ☐	Other (Please Specify):____
Heart Surgery ☐	Stroke ☐	Cancer ☐	

Nature of Illness:	Date Symptoms first appeared:	List full name, address and phone # of your Primary Care Physician:

List full name and address of all hospitals where treated for this condition.

List full name and address of any other medical providers who have treated you and their specialty.

Name	Address	Phone #	Specialty	Date First Seen

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

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Phone (800) 366-8354, FAX 1-580-255-0951

ATTENDING PHYSICIAN'S STATEMENT OF CLAIM

TO BE FULLY COMPLETED BY YOUR PRIMARY TREATING PHYSICIAN.

SECTION I: PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First, middle initial, last nam

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (First, middle initial, last name)

4. PATIENT'S ADDRESS (Street, city, state, zip)

5. PATIENT'S SEX

☐ MALE ☐ FEMALE

6. INSURED'S ID # or MEDICARE # (include any letters)

7. INSURED'S SOCIAL SECURITY #

8. INSURED'S POLICY #

9. DATE FIRST CONSULTED FOR THIS CONDI

10. DATE LAST TREATED

10. WAS PATIENT TREATED BY ANOTHER PHYSICAN(S), PRIOR TO YOUR TREATMENT

☐ YES ☐ NO

IF 'YES', PROVIDE NAME & ADDRESS OF ALL PHYSICIAN'S KNOWN

11. DATE SYMPTOMS FIRST APPEARED

12. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS

☐ YES ☐ NO

IF 'YES', PROVIDE DETAILS INCLUDING DATES OF TREATMENT AND DIAGNOSIS

13. IF YOU REFERRED PATIENT TO ANOTHER PHYSICIAN, PLEASE PROVIDE NAME , ADDRESS OF PHYSICIAN, DATE OF REFERRAL

Date of Referral:

14. IS CONDITION DUE TO AN ACCIDENT ? ☐ YES ☐ NO

15. IF YES, HOW DID ACCIDENT HAPPEN?

16. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if not home or office

17. DID YOU ORDER HOSPITAL CONFINEMENT

☐ YES ☐ NO

18. FOR SERVICES RELATED TO HOSPITALIZATION, NAME & ADDRESS OF FACILITY

DATE ADMITTED DATE DISCHARGED

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

1.
2.
3.
4.
5.

20. SIGNATURE OF PHYSICIAN OR SUPPLIER

DATE

21. YOUR SSN

23. YOUR TAX ID #

22. PHYSICIAN'S/SUPPLIER'S NAME, ADDRESS, PHONE #

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 am entitled to receive a copy of this authorization upon request.

CONTINUED

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

____

____

____

____
Claimant Name

____
Name of claimant's personal representative, if applicable

____
Relationship of personal representative to the claimant

____
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.

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 with 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 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."