LIFE INSURANCE COMPANY OF ALABAMA
P.O. BOX 349, GADSDEN, AL 35902

# CLAIMANT'S STATEMENT FOR DREAD DISEASE CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please submit the completed form to the above address along with the following information:

(1) Cytology or other lab reports diagnosing the condition you are claiming.
(2) A fully itemized statement of expenses with CPT procedure codes.

POLICYHOLDERS NAME _____ POLICY NO(S) _____

ADDRESS _____

PHONE _____-_____-_____ SS# _____-_____-_____ DATE OF BIRTH _____-_____-_____

❑ Check here if New Address ❑ Male ❑ Female

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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 _____ SS#_____-_____-_____

Date of Birth _____-_____-_____ Relationship to Policyholder_____

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What condition are you claiming? _____

Date Physician was first consulted for this condition _____

Primary Physician'sName:_____

Address _____ Phone No _____-_____-_____

1st Physician's Name _____ Phone No _____-_____-_____

Address _____

2nd Physician's Name _____ Phone No _____-_____-_____

Address _____

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

Name of Hospital _____ Phone No _____-_____-_____

Address of Hospital _____

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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