



A member of the American Fidelity Group

Local Phone # 523-5025

Toll Free # 1-800-662-1113 Ext. 4011

**INDIVIDUAL CANCER OR HOSPITAL INDEMNITY BENEFIT STATEMENT  
RETURN BENEFIT FORM AND ATTACHMENTS TO:**

**AMERICAN FIDELITY ASSURANCE COMPANY**

**ATTN: Benefit Department**

**P.O. Box 25160, Oklahoma City, OK 73125**

The laws of some states require us to furnish you with the following notice:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement is guilty of insurance fraud.

**INSTRUCTIONS TO INSURED**

- 1. Complete STATEMENT OF INSURED.
- 2. Attach an ITEMIZED HOSPITAL BILL.
- 3. Have physician complete ATTENDING PHYSICIAN'S STATEMENT.
- 4. If claim is for CANCER BENEFIT, include PATHOLOGIST'S REPORT.

**STATEMENT OF INSURED**

1. FULL NAME \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Account No. \_\_\_\_\_  
(Please Print) (Last) (First) (M.I.) (Mo) (Day) (YR)  
 Social Sec. # \_\_\_\_\_
2. Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)
3. If claim is for dependent, give name of dependent \_\_\_\_\_ Relationship \_\_\_\_\_
4. Date accident occurred or sickness began \_\_\_\_\_ 19\_\_\_\_
5. Nature of sickness or injury \_\_\_\_\_
6. Has this disease caused previous trouble? \_\_\_\_\_ If so, when \_\_\_\_\_ 19\_\_\_\_
7. Date first treated \_\_\_\_\_ 19\_\_\_\_
8. Have you been confined to a hospital?  Yes  No If so, when From: \_\_\_\_\_ To: \_\_\_\_\_
9. Name and address of hospital \_\_\_\_\_
10. Names and addresses of any doctors patient has consulted in the past year. \_\_\_\_\_

These statements are true and complete to the best of my knowledge. I authorize any insurer, physician or hospital to disclose any information regarding my (or my dependent's) insurance coverage or medical history, to American Fidelity Assurance Company.

Signature of Patient \_\_\_\_\_  
(Required only if patient is spouse)

Date \_\_\_\_\_ Signature of Insured \_\_\_\_\_

**ATTENDING PHYSICIAN'S STATEMENT**

1. Patient's name \_\_\_\_\_ Age \_\_\_\_\_
  2. Nature of sickness or injury \_\_\_\_\_ (ICDA Code) \_\_\_\_\_
  3. When did symptoms first appear or accident happen? Date \_\_\_\_\_ 19\_\_\_\_
  4. When did patient first consult you for this condition? Date \_\_\_\_\_ 19\_\_\_\_
  5. Has patient ever had same or similar condition?  Yes  No (If "Yes" state when and describe)
  6. Was patient referred to you by another physician?  Yes  No If so, list name and address \_\_\_\_\_
  7. Name \_\_\_\_\_ Address \_\_\_\_\_
  8. If patient hospitalized, give name and address of hospital. Admitted \_\_\_\_\_ 19\_\_\_\_  
 Discharged \_\_\_\_\_ 19\_\_\_\_
- Date \_\_\_\_\_ 19\_\_\_\_ Signed \_\_\_\_\_ Degree \_\_\_\_\_  
(Attending Physician)

(Street Address)

(City or Town)

(State)

(Zip Code)