

THE LOYAL AMERICAN CLAIMS PROCESSING  
ADDRESS HAS CHANGED. MAIL CLAIMS TO:

LOYAL AMERICAN LIFE INSURANCE COMPANY  
CLAIMS PROCESSING OFFICE  
PO BOX 1604  
DUNCAN, OK 73534-1604

INSTRUCTIONS FOR FILING A CLAIM  
LIMITED BENEFIT CANCER EXPENSE POLICY

The forms must be completed by the claimant. 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.**

- The enclosed **Statement of Claim** should be fully completed by the primary insured and the patient. Please make sure the Authorization at the bottom of the page is signed and dated.
- A **Pathology Report** showing a positive diagnosis of Cancer and the date it was made. This can be obtained from the physician.
- **Itemized Hospital Bills:** Please obtain from the hospital or outpatient facility the UB92 standard billing form showing the diagnosis, along with the detail billing indicating line by line description of services.
- **Itemized Physician Bills:** Please obtain a HCFA1500 from the physicians for surgery, anesthesiology, chemotherapy and radiation therapy. Itemized billings which provide us with the diagnosis, procedure codes, charges and service dates are also acceptable.
- **Primary Carrier EOB's:** Please attach your primary carrier's explanation of benefits to your itemized bills
- 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.

**If your condition was diagnosed within the first two (2) years of your policy's effective date, it is considered contestable. We may request medical records from the physicians who have treated you within the five (5) years prior to the policy effective date. Please make sure to provide a list of the full names, addresses and telephone numbers of all physicians who have treated you.**

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

**LOYAL AMERICAN LIFE INSURANCE COMPANY®**

P.O. Box 559004  
Austin, Texas 78755-9004

**INSURED'S STATEMENT - Limited Health Benefits Claim**

Policy Number _____	Name of Patient _____	<input type="checkbox"/> Male	Date of Birth _____
		<input type="checkbox"/> Female	
Name and Address of Primary Insured _____		<input type="checkbox"/> Male	Date of Birth _____
		<input type="checkbox"/> Female	
		Social Security No. _____	Telephone _____ (    )
Spouse's Name _____			
Patient is:			
<input type="checkbox"/> Primary Insured	<input type="checkbox"/> Spouse	<input type="checkbox"/> Married	<input type="checkbox"/> Employed
<input type="checkbox"/> Natural Child	<input type="checkbox"/> Step-Child	<input type="checkbox"/> Unmarried	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Adopted Child	<input type="checkbox"/> *Other Child	<input type="checkbox"/> Divorced	<input type="checkbox"/> Student
		<input type="checkbox"/> Legally Separated	(Where?) _____
* (If "Other" please explain): _____			
Home Address of Patient _____			
Address _____ City or Town _____ State (or Province) _____ Zip Code _____			
Nature of Loss		Date of Accident or First Symptoms of Sickness _____	Date of First Treatment _____
<input type="checkbox"/> Sickness	<input type="checkbox"/> Pregnancy	If Accident, Describe how it happened _____	
<input type="checkbox"/> Accident	<input type="checkbox"/> Complication of Pregnancy		
Physician's Name and Address _____			
Medical Treatment in Last Five Years			
Physician	Condition Treated	Dates	
_____	_____	_____	
Is This The First Claim On This Patient? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Is This Claim Covered By Any State Or Federal Worker's Compensation, Employer's Liability Law Or Similar Law? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If You and Your Spouse Have Been Hospital Confined At The Same Time Due to Injuries sustained In The Same Accident, Please Give Dates Of Treatment You: (from _____ to _____ ) Spouse: (from _____ to _____ )			
We certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief.			
_____	<b>X</b>	_____	<b>X</b>
Date	Signature of Insured	Signature of Patient (Parent if minor)	
<b>INSTRUCTIONS FOR FILING CLAIM</b>			
1. Complete Insured's Statement and sign in the spot indicated below. (this is a 2 sided form)			
2. Sign the Authorization Form For Disclosures Of A Claimant's Protected Health Information (HIPAA)			
3. Attach copies of bills and/or treatment notes for any other treatment, such as hospital, physician or other covered expenses. <u><b>Bills must have a diagnosis code or other indication from a physician of the condition(s) treated and service(s) rendered.</b></u>			
4. Send the completed forms to the address on the top of this form Attn: Medical Claims Department			
3. For assistance, call toll free 1-800-633-6752.			
<b>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.</b>			
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	

## FRAUD WARNING STATEMENTS

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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."



**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. The Company, as used in this authorization, shall mean:
  - Great American Life Insurance Company's® Long Term Care Division
  - Loyal American Life Insurance Company®
  - United Teacher Associates Insurance Company
2. 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, Web ISG.
3. 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.
4. 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 26580, Austin, Texas 78755-0580.
5. This authorization will expire twenty-four (24) months from the date the authorization is signed.
6. 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
7. 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.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original.
9. I understand that I or my personal representative am entitled to receive a copy of this authorization upon request.

**CONTINUED ON OTHER SIDE**

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

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Claimant Name

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Name of claimant's personal representative, if applicable

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Relationship of personal representative to the claimant

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Signature of claimant (or claimant's representative)

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Date of claimant's (or claimant's representative) signature

A signed copy of this form will be provided any time upon request.

# GREAT AMERICAN FINANCIAL RESOURCES

UNITED TEACHER ASSOCIATES INSURANCE COMPANY  
 PO BOX 26580, AUSTIN, TX 78755-6580  
 Phone (800) 880-8824

LOYAL AMERICAN LIFE INSURANCE COMPANY®  
 PO BOX 559004, AUSTIN, TX 78755-9004  
 Phone (800) 633-6752

## ATTENDING PHYSICIAN'S STATEMENT OF CLAIM

**TO BE FULLY COMPLETED BY YOUR PRIMARY TREATING PHYSICIAN.**

SECTION II: PATIENT & INSURED (SUBSCRIBER) INFORMATION		
1. PATIENT'S NAME (First, middle initial, last name) _____	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 <input type="checkbox"/> MALE <input type="checkbox"/> 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 CONDITION _____	10. DATE LAST TREATED _____	10. WAS PATIENT TREATED BY ANOTHER PHYSICIAN(S), PRIOR TO YOUR TREATMENT <input type="checkbox"/> YES <input type="checkbox"/> NO
11. DATE SYMPTOMS FIRST APPEARED _____		If 'YES', PROVIDE NAME & ADDRESS OF ALL PHYSICIAN'S KNOWN _____ _____ _____
12. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS <input type="checkbox"/> YES <input type="checkbox"/> 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 _____ _____ _____
14. IS CONDITION DUE TO AN ACCIDENT ? <input type="checkbox"/> YES <input type="checkbox"/> NO	15. IF YES, HOW DID ACCIDENT HAPPEN? _____	Date of Referral: _____
16. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if not home or office) _____ _____ _____ _____		17. DID YOU ORDER HOSPITAL CONFINEMENT <input type="checkbox"/> YES <input type="checkbox"/> 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 # _____ _____ _____