

## CLAIMANT'S STATEMENT FOR LUMP SUM CANCER CLAIM

Please complete the Claimant's Statement, answering ALL questions on the form. Please complete the Authorization to Release Information and Medical Provider & Employer List. Please submit the completed forms to the above address along with the following information:

- (1) A Pathology Report first diagnosing malignant cancer.
- (2) Attending Physician's Statement completed by the physician.

POLICYHOLDER'S NAME \_\_\_\_\_ POLICY NUMBER(S) \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CHECK HERE IF NEW ADDRESS  MALE  FEMALE

Employer's Name: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

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 \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Policyholder \_\_\_\_\_

What type of cancer were you diagnosed with? \_\_\_\_\_

What date were you diagnosed with cancer? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

What date did you first consult the Physician for this condition? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Prior to this diagnosis, have you ever been diagnosed with a malignant cancerous condition? Yes  No

If yes, when were you diagnosed? \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ What type of Cancer? \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1<sup>st</sup> Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2<sup>nd</sup> Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If you were hospitalized: Date Admitted \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Discharged \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Hospital \_\_\_\_\_

Address of Hospital \_\_\_\_\_

**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