American Public Life Insurance Company
A member of the American Fidelity Group

American Public Life Insurance Company
Mail to: Claims Department
P.O. Box 248850
Oklahoma City, OK 73124-8850
Toll Free Phone #: 1-888-839-5720
Local Phone #: 405-523-2030
Toll Free Fax #: 1-866-265-4588

INDIVIDUAL CANCER, INTENSIVE CARE, OR DREAD DISEASE BENEFIT STATEMENT

INSTRUCTION TO INSURED

1. Fully complete the Statement of Insured Information section of this claim form.
2. Attach itemized charges, with diagnosis, from anesthesiologist, surgeon, hospital, or medical facility.
3. **To receive payment for CANCER BENEFIT,** please attach a pathology report showing the diagnosis of a malignancy.
4. Please submit ALL information requested to the address or fax number above.

STATEMENT OF INSURED

Insured's Name:	Insured's Date of Birth:	Insured's Social Security Number:
Mailing Address:	City:	State/Zip Code:
Insured's Customer Number:	Home Telephone Number:	Work Telephone Number:

PATIENT INFORMATION

Patient's Name:	Patient's Date of Birth:	Patient's Social Security Number:

Relationship To Insured: Self ❒ Husband ❒ Wife ❒ Son ❒ Daughter ❒ Other ❒ _____ (specify relationship)

If claim is for a dependant child age 22 or over are they a full-time student? Yes ❒ No ❒ If yes, please provide supporting documentation of full-time status.

CLAIM INFORMATION

1. Claim is for: Preventative Care Benefits ❒ Cancer Benefits ❒ First Occurance Benefit ❒ Intensive Care Benefits ❒ Dread Disease Benefits ❒
2. Diagnosis/Condition:_____

   Please list date first treated: _____ If Cancer Benefits have been requested, please indicate date first diagnosed: _____
3. Have you been confined to a hospital? Yes ❒ No ❒ If yes, please list admittance date and discharge date: From _____ To _____
4. Name of Hospital: _____ Address: _____

(COMPLETE IF DIAGNOSIS WAS MADE WITHIN THE FIRST YEAR OF COVERAGE)

5. Please list the name, phone number, and address of all physicians' the patient has consulted in the past five years:(Attach additional sheet if necessary.)

_____

_____

_____

Print Name:_____ Signature:_____ Date:_____

Please retain a copy for your personal records, or you may request a copy from our company.

Certain products administered by American Public Life Insurance Company are underwritten by American Fidelity Assurance Company.

STATE FRAUD WARNINGS

AL, AK, CT, GA, IL, IA, KS, ME, MA, MI, MS, MO, MT, NE, NV, NY, NC, ND, RI, SC, SD, TN, UT, VT, VA, WA, WI, WY

"Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties."

AR, DC, LA, MD, NJ, NM, TX, WV

"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."

Arizona – "For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

California – "For your protection California Law requires the following to appear on the form. Any person who knowingly presents 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."

Colorado – "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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

Delaware - "WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony."

Florida – "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."

Hawaii – "For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

Idaho – "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Indiana – "WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Kentucky – 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.

Minnesota – "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

New Hampshire – "Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

Ohio – "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Oklahoma – "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania - "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."

Puerto Rico - "Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years."

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CLAIMS DEPARTMENT

PHONE: (888) 839-5720
LOCAL: (405) 523-2030
FAX: (866) 265-4588

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Customer # _____ Today's Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

For dates of treatment beginning _____ and ending _____, *I authorize release of the following information (check all which applies):*

History Sheets____ Abstract of ALL records / ALL Pertinent Information _____

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Public Life Insurance Company (APL) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacies; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carriers. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome/AIDS Related Complex) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to APL North Claims Department, PO Box 248850, Oklahoma City, Oklahoma 73124-8850 or by calling, toll-free, 1-888-839-5720. I understand that my right to revoke this authorization is limited to the extent that: action has been taken in reliance on the authorization; or the law provides the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

_____
Printed Name (Patient)

_____
Signature (Patient) or Personal Representative (if applicable)

_____
Date Signed

_____
Relationship of Personal Representative to Patient

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

Please retain a copy for your personal records, or you may request a copy from our Company.