LOYAL AMERICAN LIFE INSURANCE COMPANY®
PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604
Phone (800) 366-8354

Statement of Claim - Accident Expense - Individual Policy

To be completed by the Insured (Complete all applicable sections)

Insured's name:	Insured's address: Phone: ( )	☐ Check here if your address has changed	Policy/Certificate No.
Insured's date of birth:	Social Security No.:	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Employer's name & address:
Claim is for: ☐ Self ☐ Child ☐ Spouse	Claimant's name (if not insured):	Sex of claimant: ☐ Male ☐ Female	Claimant's date of birth:
If dependent child is over age 19, indicate: ☐ Handicapped ☐ Student	If full time student, give name and address of school:		Claimant's occupation:
How did the accident happen?	Where did it occur?	Date of accident:	Time of accident: Hour ☐ A.M. ☐ P.M
	Employment related? ☐ Yes ☐ No	Worker's Compensation claim filed? ☐ Yes If yes: Date filed: _____ ☐ No Claim #: _____	
Type of Treatment ☐ Emergency Room ☐ Hospital - OutPatient ☐ Hospital - InPatient ☐ M.D.'s Office	List full name and address of all facilities where treated for this condition:		
List full name and address of all Physicians who have treated you for this condition.			

INSTRUCTIONS FOR FILING AN ACCIDENT CLAIM

1. Please provide a copy of the **Accident Report** if one is available
2. Please provide an **Itemized Emergency Room Bill with Diagnosis or Emergency Room Notes**
3. Please provide copies of itemized bills and/or treatment notes which include the diagnosis for any other related treatment, such as hospital, physician, physical therapist or ambulance bil
4. The enclosed **HIPAA**form, Authorization Form For Disclosures of a Claimant's Protected Health Information, should be fully completed by the **patient.**
5. 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.

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.

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.

Date _____ Signature of CLAIMANT or Insured if Minor _____ Present Address _____