



Attention: Claims Department
 P.O. Box 1650
 Little Rock, Arkansas 72203-1650
 Telephone (800) 370-5856
 Fax (501) 235-8416

Statement of Claim

Heart Attack, Heart Disease or Stroke Benefits

For H.O. Use Only	
Eff	_____
PTD	_____
Plan Code	_____
Issue Age	_____

- Instructions:**
1. Please make sure all questions on Insured's statement are completed in full.
 2. Authorization must be signed and currently dated.
 3. Physician Statement on page 2 (reverse side) must be completed.
 4. Please type or print in blue or black ink.

INSURED'S STATEMENT

Insured Name (Last, First)		Policy Number (Very Important)	
Home Address (City, State, Zip)		Telephone Numbers	
		Home	Work
Patient Name (Last, First)	Patient's SSN	Date of Birth	Relation to Insured

Describe symptoms: _____

Date of first treatment: _____

Name and address of first doctor seen: _____

Names and addresses of all doctors and hospitals consulted for **this** condition (Use separate sheet if necessary):

Physician/Hospital	Address, City, State and ZIP
_____	_____
_____	_____
_____	_____

Have you ever had this or similar condition before? Yes No

If yes, give particulars: _____ Date: _____

Describe: _____

Names and addresses of all doctors and hospitals consulted for **ANY** condition in the past five years (Use separate sheet if necessary):

Physician/Hospital	Address, City, State and Zip	Condition
_____	_____	_____
_____	_____	_____

Authorization to Obtain Information

In signing below, I represent that the statements and answers given are true, complete and correctly recorded. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to USABLE Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge I have a right to a copy of this authorization upon request.

FRAUD WARNING: Except as noted in separate Fraud Notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date: _____ **Signature of Patient:** _____

(Parent/Guardian if Minor)

Please have your Attending Physician complete page 2 (reverse side) and attach itemized copies of your bills.

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ATTENDING PHYSICIAN'S STATEMENT

Please answer all questions and attach itemized bill for all covered services to date.

Diagnosis and concurrent conditions (Include ICD Code)

Date symptoms first appeared _____	Date patient first consulted you _____
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If hospitalized, date _____

Inpatient Outpatient

Hospital Name _____

City, State _____

Have you treated this patient for other conditions? Yes No

If yes, give dates and describe _____

Has patient ever had same or similar condition?

No Yes, Date _____

Was patient referred to you? Yes No

If yes, name and address of referring doctor _____

Physician's Signature			Date
Physician's Name		Degree	
Address		Telephone	
City	State	Zip	Fax