



<i>First, Middle, Last</i>			
Policyowner's Name		Policy no.	
<i>Street address</i>	<i>City</i>	<i>State</i>	<i>Zip code +4</i>
Address			
Phone no. ()	Social Security no.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Policyowner's date of birth <i>MM/DD/YYYY</i>

CLAIM INFORMATION	<i>First, Middle, Last</i>
	1. Claimant's name _____
	2. Date of birth _____ (<i>MM/DD/YYYY</i>)
	3. Relationship to Policyowner _____
<p>To file a cancer claim under your Assurity policy, please provide an itemized bill showing the following:</p> <ul style="list-style-type: none"> • Patient's name • Diagnosis code • Date of service • Procedure code and CPT code (<i>this should appear on your itemized billing from the provider</i>) • Dates of confinement (<i>if applicable</i>) <p>A pathology report and any additional medical records would also be helpful in processing your claim. An authorization to release medical information may be needed. Please contact Assurity's claim department at (800) 869-0355, extension 4484 with any questions or to request an authorization form.</p> <p>Claims can be faxed to (800) 869-0368 or mailed to Assurity at the address on the top of this form.</p>	

IMPORTANT: Prior to submitting this completed form, please read your specific state fraud notice on form 01-004-05055. The Fraud Notice form must be signed and submitted with this form.

I hereby acknowledge that I have read the applicable state fraud notice information on form 01-004-05055.

I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.

*Date (MM/DD/YYYY)**Signature of Policyowner or legal representative**Printed name of person completing this form*



