

AMERICAN INCOME LIFE INSURANCE COMPANY

P.O. Box 2608 Waco, Texas 76797
(254) 761-6400 www.aillife.com

1. Claim Form Must Be Completed By INSURED, DOCTOR and, for disability claims only, the EMPLOYER.
2. Mail With The Claim Form All Itemized Doctor and Hospital Bills.
3. Mail The Form In Yourself. Do Not Leave It For The Doctor to Mail.

PART A CLAIMANT'S STATEMENT - TO BE COMPLETED ON ALL CLAIMS			
Policy Numbers <input style="width: 150px; height: 20px;" type="text"/> <input style="width: 150px; height: 20px;" type="text"/> <input style="width: 150px; height: 20px;" type="text"/> <input style="width: 150px; height: 20px;" type="text"/> 			
Policyowner's name		Policyowner's address	
Policyowner's employer		Policyowner's occupation	
Policyowner's union and local			
Patient's name		Names of other insurance companies which cover this claim	
Patient's birthdate	Relation to policyowner		
List the names and addresses of doctors consulted for this accident or sickness and dates of treatment.			
DOCTOR	ADDRESS		DATES
If hospitalized, name and address of hospitals and dates of confinement.			
HOSPITAL	ADDRESS		DATES
Date that symptoms first appeared		Date of first treatment by doctor	
Nature of sickness or accident		If an accident, how did it happen?	Date of accident
Have you ever had symptoms of this condition before? <input type="checkbox"/> Yes <input type="checkbox"/> No When?			
Date required to give up work		Date returned to work	
List all sickness or injuries for which treatment was required in the past five years.			
CONDITION	DATE	CONDITION	DATE

For your protection, laws in certain jurisdictions require the following to appear on this form.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 and subjects such person to criminal and civil penalties.

Claimant's Signature **X** _____

E-mail address _____

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

Patient's Signature **X** _____

Date _____

Patient's Address _____

Phone # _____



