

**American Fidelity
Assurance Company**

A member of the American Fidelity Group

Local Phone # (405) 523-5025
Toll Free # (800) 662-1113
Fax Toll Free # (800) 818-3453

**INDIVIDUAL CANCER DIAGNOSTIC BENEFITS STATEMENT
RETURN THIS BENEFIT FORM AND ATTACHMENTS TO:
AMERICAN FIDELITY ASSURANCE COMPANY
American Fidelity Educational Services
ATTN: BENEFITS DEPARTMENT
P.O. BOX 25160
OKLAHOMA CITY, OK 73125**

The laws of some states require us to furnish the following notice:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement is guilty of insurance fraud.

INSTRUCTION TO INSURED

1. Complete STATEMENT OF INSURED
2. Please attach bill, receipt, or evidence of the test

STATEMENT OF INSURED

1. FULL NAME _____ Date of Birth ____/____/____
(Please Print) (Last) (First) (M.I) (Mo.) (Day) (Yr.)

Social Sec. # _____ - _____ - _____

2. Address _____
(Street) (City) (State) (Zip Code)

3. If claim is for dependent, give name of dependent _____ Relationship _____

Date of Birth ____/____/____
(Mo.) (Day) (YR)

DIAGNOSTIC TESTING BENEFIT

- Covered diagnostic tests and benefits amounts vary by series of the plan.
- Please read your policy for the covered diagnostic tests and the exact amount of your benefit.

MAIL TO:

**American Fidelity Assurance Company
American Fidelity Educational Services
Attn: Benefits Dept- Cancer Claim
P.O. Box 25160
Oklahoma City, OK 73125-0160**