CENTRAL UNITED CANCER PLAN CLAIM FORM -

REPORT OF CANCER OR SPECIFIED DISEASE CLAIM

PATIENT'S NAME		DATE OF BIRTH	POLICY NUMBER
ADDRESS			SOCIAL SECURITY NUMBER
POLICYHOLDER'S NAME			RELATIONSHIP TO POLICYHOLDER
WHAT IS THE NATURE OF YOUR ILLNESS?	DATE DIAGNOSED		DATE OF FIRST TREATMENT

PHYSICIAN NAME AND ADDRESS

WERE YOU HOSPITALIZED? YES____ NO ____ DATE OF CONFINEMENT ____________ THROUGH ____________

NAME AND ADDRESS OF HOSPITAL ________________________________

HAVE YOU EVER HAD A SIMILAR ILLNESS? YES____ NO____ IF SO, WHEN ________________

I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such company to Central United Life Company or their duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

Date: ________________ Signature of Insured: ________________________________

Social Security #

Signature of Patient: ________________________________

Required only if patient is spouse or over age 18

Address ________________________________

City ________________ State ________ Zip ____________

Return this Claim form and Itemized Medical Bills to:

Central United Life Insurance Company
Wortham Tower
2727 Allen Parkway, Sixth Floor
Houston, TX 77019-2115

1-800-669-9030
Claim Dept Fax (713) 529-5863

INSURANCE FRAUD WARNING

Any person who, with intent to injure, deceive, or defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of a crime.

CA-01-10/96