

# CENTRAL UNITED LIFE INSURANCE

## 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:

Claims Department  
P.O. Box 925309  
Houston, TX 77292-5309  
1-800-669-9030

**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.