

ASSURITY LIFE INSURANCE COMPANY  
1526 K Street - PO Box 82533  
Lincoln, NE 68501-2533  
Toll Free 800-869-0355 • Fax 402-437-4592

**CRITICAL ILLNESS CLAIM QUESTIONNAIRE  
TO BE COMPLETED BY CLAIMANT**

1. PERSONAL INFORMATION Policy number \_\_\_\_\_

Name: \_\_\_\_\_  
Last Name First Name

Date of birth: \_\_\_\_\_ Telephone: Home: ( ) - \_\_\_\_\_  
Office ( ) - \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**2. DETAILS OF CRITICAL ILLNESS:**

a) Please describe your illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of diagnosis or operation \_\_\_\_\_

b) <sup>1</sup> When did the first symptoms appear? Please describe the symptoms:  
\_\_\_\_\_  
\_\_\_\_\_

c) When did you first consult a Physician for this condition?  
\_\_\_\_\_

Name & address of that attending Physician:  
\_\_\_\_\_

d) Please provide details and dates of tests or exams to confirm the diagnosis?  
\_\_\_\_\_  
\_\_\_\_\_

e) Did you previously suffer from or receive treatment for the same or a similar condition? If yes,  
please provide details and dates:  
\_\_\_\_\_  
\_\_\_\_\_

**3. MEDICAL CONSULTATIONS**

a) Name and address of your personal Physician: \_\_\_\_\_  
\_\_\_\_\_

b) Names, addresses and dates seen of any other Physicians or specialists consulted for this disease:

---

---

---

c) Name, address, date admitted and discharged from any hospital or other medical facility:

---

---

---

d) Describe current and past treatments for this disease:

Type of treatment Hospital/Institution / Treating Physician Dates

---

---

---

#### 4. GENERAL INFORMATION

a) Has anyone in your direct family (parents or siblings) suffered from this or similar disease? If yes, please provide:

Relationship                      Disease                      Age when first diagnosed

---

---

b) Please provide any other information that may be useful in the assessment of your claim.

---

---

---

#### 5. DECLARATION AND AUTHORIZATION

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or 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 shall also be subject to a substantial civil penalty where and to the extent allowed by state law.**

I hereby agree to reimburse Assurity Life Insurance Company to the extent of any overpayment which is in excess of the amounts payable under the individual plan administered by Assurity Life Insurance Company. I hereby certify the statements hereon are complete and accurate to the best of my knowledge.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**ASSURITY LIFE INSURANCE COMPANY**  
P.O. Box 80926 Lincoln, NE 68501-0926

**CANCER SCREENING REIMBURSEMENT CLAIM FORM**

Routine cancer screenings can play an important role in achieving and maintaining a healthy lifestyle. Early detection of cancer often leads to additional treatment options and a greater chance of fighting this disease. Because we care about you and know the importance of these screenings, we have made the claim filing process easy for you!

If you have one of the cancer screening tests listed below, you can elect to not submit a copy of the medical bill and simply complete this claim form and then fax or mail it to us. We'll promptly review your claim for benefits! If your cost for the cancer screening test exceeds the amount shown below (up to \$100), you can send us a copy of the medical bill along with this form. If you have a cancer screening test not listed below, a copy of the medical bill is needed for us to review your claim for benefits. Please complete a separate claim form for each family member. You may fax this form to us toll-free at 1-800-869-0368, or if you prefer, you can mail it to us at the above address.

If you have any questions, please feel free to call and speak to any one of our Customer Service Representatives at 1-888-358-8808 ext. 4, from 9:00 a.m. to 5:00 p.m. Eastern Standard Time.

**To Be Completed By Insured**

Insured's Name: \_\_\_\_\_ Assurity Policy Number: \_\_\_\_\_

Insured's Address \_\_\_\_\_

Claimant's Name: \_\_\_\_\_ Claimant's Date of Birth: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_ Date of Test: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Physician's Phone Number: (\_\_\_\_) \_\_\_\_\_

Physician's Address: \_\_\_\_\_

*Your Assurity Cancer policy will pay the amount charged up to a maximum of \$100 per calendar year for each insured person who has cancer screening tests performed while this policy is in force. Many of the common cancer screening tests are listed below. We have indicated next to each test the amount we will pay for the test if you do not send us a copy of the medical bill. Please refer to your policy for benefits and limitations.*

• Please check the Cancer Screening Test(s) received by you or a covered family member on the above date.

- |   |  |
|---|--|
| † Mammography / breast ultrasound \$75        | † CEA (blood test for colon Cancer) \$50 |
| † Pap smear / Thin Prep Pap (test only) \$25  | † Colonoscopy \$100                      |
| † CA 125 (blood test for ovarian Cancer) \$50 | † Chest X-ray \$50                       |
| † PSA (blood test for prostate Cancer) \$50   | † Thermography \$50                      |
| † Hemocult stool specimen \$10                | † Serum protein electrophoresis \$25     |
| † Flexible sigmoidoscopy \$100                |  |

I certify that the above statements are true and correct and hereby authorize any physician or other health care provider to give Assurity any additional information needed in connection with this claim. If a special authorization is required by my physician to confirm the above information, I will promptly complete any authorization requested of me and return to Assurity.

Date: \_\_\_\_\_ Claimant's Signature: \_\_\_\_\_  
Or Parent/Guardian If Claimant Is A Minor

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

