Loyal American
Life Insurance Company®

Wellness Claim

To: **From:**

Fax: **Pages:**

Phone: **Date:**

INSTRUCTIONS

ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE, AND CHARGE(S). FOR ASSISTANCE, CALL TOLL-FREE 800-366-8354.

Policy Number_____**Patient**_____

Date of Birth_____**Male ☐ Female ☐ Student ☐ If student, where?** _____

Name and Address of Primary Insured

_____

_____

_____

_____

Patient is:

☐ Primary Insured

☐ Spouse

☐ Child

☐ Other