AMERICAN FIDELITY
a different opinion

Worksite Group Benefits Department | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
American Fidelity Assurance Company | 1-800-662-1113 | Fax: 1-800-818-3453 | **americanfidelity.com**

STATEMENT OF INSURED *To be completed by Employee*

Name: (last, first, middle initial)	Date of Birth: / /
Social Security Number: / /	Account Number:
Mailing Address: (P.O. Box or street, city and zip code)	
Telephone Number (including area code):	Email Address:
Employer Name:	
For whom do you make this request (check one): ❒ Self ❒ Spouse ❒ Child ❒ Other	
Patient Name: (last, first, middle initial)	
Patient Date of Birth: / /	Patient Social Security Number: / /

PLEASE NOTE: Your specific policy may not include all of the following benefits. Please refer to your policy documents for available coverage details.

SECTION 1 — CRITICAL ILLNESS BENEFITS

STATEMENT OF ATTENDING PHYSICIAN To be completed by Physician.

Please complete the appropriate section for each condition that the patient has been diagnosed.

CANCER

Does the patient have cancer? ❒ Yes ❒ No	Type of cancer: Date cancer diagnosed: / /
Stage of Cancer:	Is this an In Situ Cancer? ❒ Yes ❒ No

COMA

Is the patient in a comatose state? ❒ Yes ❒ No	Was the coma medically induced? ❒ Yes ❒ No
Date the coma was diagnosed based on documented neurological dysfunction and prolonged unresponsiveness: / /	
What caused the coma:	
Did the patient's coma produce severe neurological dysfunction and unresponsiveness persisting for more than 14 days? ❒ Yes ❒ No	

CORONARY ANGIOPLASTY

Does the patient have coronary artery disease? ❒ Yes ❒ No	Date Coronary Artery Disease was diagnosed: / /
Date Coronary Angioplasty was recommended: / /	Date Coronary Angioplasty occurred: / /

CORONARY BYPASS SURGERY

Does the patient have coronary artery disease? ❒ Yes ❒ No	Date Coronary Artery Disease was diagnosed: / /
Date Coronary Bypass Surgery was recommended: / /	Date surgery occurred: / /

AMERICAN FIDELITY
a different opinion

Worksite Group Benefits Department | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
American Fidelity Assurance Company | 1-800-662-1113 | Fax: 1-800-818-3453 | **americanfidelity.com**

STATEMENT OF ATTENDING PHYSICIAN, CONTINUED

END STAGE RENAL FAILURE

Does the patient have End Stage Renal Failure presenting as chronic, irreversible failure to function of both kidneys? ❒ Yes ❒ No	Does the patient's kidney failure necessitate regular peritoneal or hemodialysis (at least weekly) or kidney transplantation? ❒ Yes ❒ No
Date of recommendation for patient to begin renal dialysis or kidney transplant: / /	
What is the cause for patient's End Stage Renal Disease:	
Date patient was first treated for signs or symptoms of this condition: / /	

HEART ATTACK (MYOCARDIAL INFARCTION)

Are new and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction? ❒ Yes ❒ No If yes, attach a copy of the EKG.	
Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK)? ❒ Yes ❒ No	Did diagnostic studies confirm a Myocardial Infarction and the occlusion of one or more coronary arteries? ❒ Yes ❒ No
Did the patient have symptoms consistent with Myocardial Infarction? ❒ Yes ❒ No	What symptoms?
Date the patient was diagnosed with a Myocardial Infarction: / /	

MAJOR BURNS

Date the burns occurred: / /	Percentage of body surface covered by the burns: %
Degree of the burns: ❒ 1st degree ❒ 2nd degree ❒ 3rd degree ❒ 4th degree	

MAJOR ORGAN FAILURE

Has the patient been placed on the UNOS (United Network for Organ Sharing) list, requiring transplantation of any of the following: ❒ heart ❒ liver ❒ lung ❒ entire pancreas	
Date patient was placed on UNOS list: / /	
What condition caused the need for transplant?	Date patient first treated for signs or symptoms of this condition: / /

OCCUPATIONAL HIV or OCCUPATIONAL HEPATITIS B, C, D

Is the claim for: ❒ Occupational HIV – or – Hepatitis ❒ B ❒ C ❒ D	
Date patient positively diagnosed: / /	
Date the of accidental exposure to HIV or Hepatitis B/C/D-contaminated body fluids: / /	
Did the accidental exposure occur during the normal course of duties of the occupation? ❒ Yes ❒No	
Has the patient previously tested positive for HIV or Hepatitis B/C/D? ❒ Yes ❒ No	If yes, give date: / /
What event caused the HIV or Hepatitis B/C/D?	
Was a preliminary screening test performed within 14 days of the accidental exposure? ❒ Yes ❒ No	Date of the test: / /
Was a subsequent screening test performed within 26 weeks of the accidental exposure? ❒ Yes ❒ No	Date of the test: / /
Were all HIV or Hepatitis B/C/D tests blood tests approved by the FDA? ❒ Yes ❒ No	If Yes, provide name of test:
Were all HIV or Hepatitis B/C/D tests performed by a state certified, licensed laboratory? ❒ Yes ❒ No	

AMERICAN FIDELITY
a different opinion

Worksite Group Benefits Department | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
American Fidelity Assurance Company | 1-800-662-1113 | Fax: 1-800-818-3453 | **americanfidelity.com**

STATEMENT OF ATTENDING PHYSICIAN, CONTINUED

PERMANENT DAMAGE DUE TO A STROKE

Did the patient have a stroke? ❒ Yes ❒ No
For how many days did the patient's stroke produce persisting neurological deficits?
Date stroke occurred based on documented neurological deficits and neuroimaging or other neurodiagnostic study: / /

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT

Has the patient experienced permanent paralysis due to injuries to the spinal cord resulting in paraplegia or quadriplegia persisting for a period of 90 consecutive days or more? ❒ Yes ❒ No
Is paralysis expected to be permanent in nature? ❒ Yes ❒ No
Date patient first diagnosed with permanent paralysis: / /
What event resulted in paralysis:
Date patient first treated for signs or symptoms of this condition: / /

SUDDEN DEATH DUE TO CARDIAC ARREST

Date the Cardiac Arrest occurred: / /	Date of the patient's Death: / /
What condition resulted in the Cardiac Arrest:	

PHYSICIAN INFORMATION

Attending Physician's Name & Title: (print)	Specialty:
Phone:	Fax:
Mailing Address: (P.O. Box or Street, City, State and Zip Code)	
Form completed by (name and title):	Signature:
Date: / /	

SECTION 2 — HOSPITAL CONFINEMENT AND INFECTIOUS DISEASE

Was the patient or is the patient currently hospitalized? ❒ Yes ❒ No	Diagnosis:
Dates the patient was hospitalized: From: / / To: / /	
Name and address of the hospital:	