



A member of the American Fidelity Group

www.afadvantage.com

Local Phone # (405) 523-5025

Toll Free # (800) 662-1113

Fax Toll Free # (800) 818-3453

**INDIVIDUAL CANCER DIAGNOSTIC BENEFITS STATEMENT  
RETURN THIS BENEFIT FORM AND ATTACHMENTS TO:**

**AMERICAN FIDELITY ASSURANCE COMPANY**

**American Fidelity Educational Services**

**ATTN: BENEFITS DEPARTMENT**

**P.O. BOX 25160**

**OKLAHOMA CITY, OK 73125**

Warning: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

**INSTRUCTION TO INSURED**

1. Complete STATEMENT OF INSURED
2. Please attach **bill, receipt, or evidence of the test**

**STATEMENT OF INSURED**

1. FULL NAME \_\_\_\_\_ Account No. \_\_\_\_\_  
(Please Print) (Last) (First) (M.I.)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. # \_\_\_\_-\_\_\_\_-\_\_\_\_  
(MO) (Day) (YR)

2. Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

3. If claim is for dependent, give name of dependent \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Mo) (Day) (YR)

For dependent children between 21-25 years of age please provide: School Name: \_\_\_\_\_  
Hours Currently Enrolled \_\_\_\_\_

**DIAGNOSTIC TESTING BENEFIT**

- Covered diagnostic test and benefit amounts vary by series of the plan.
- Please read your policy for the covered diagnostic tests and the exact amount of your benefit.

**MAIL TO:**

**American Fidelity Assurance Company  
American Fidelity Educational Services  
Attn: Benefits Dept - Cancer Claim  
P.O. Box 25160  
Oklahoma City, OK 73125-0160**