



**American Fidelity  
Assurance Company**

A member of the American Fidelity Group

www.afadvantage.com

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.

**STATEMENT OF POLICYHOLDER**

Patient's Name: \_\_\_\_\_

Relationship to Policyholder:  Self  Spouse  Child

Patient's Date of Birth: \_\_\_\_\_  Male  Female

For dependent children between 21-25 years of age please provide

School Name: \_\_\_\_\_

If a full time student, please enclose a copy of transcript

Policyholder's Name: \_\_\_\_\_

Cancer policy number (account no.) \_\_\_\_\_ or Social Security number of policyholder \_\_\_\_\_.

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

Check if address has changed

City, State, Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PLEASE ATTACH BILL, RECEIPT OR EVIDENCE OF THE TEST.**

**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.**