



Wellness Claim

To: Loyal American From: _____

Fax: 580-255-0951 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