



**National Teachers Associates  
Life Insurance Company**

Attn: Claims Department  
P.O. Box 2369 • Addison, TX 75001-2369  
(972) 532-2100 • (888) 671-6771  
FAX: (972) 532-2192

List Policy Numbers Here


**CLAIMANT'S STATEMENT • CANCER / HEART WELLNESS BENEFIT**

**Instructions:** Attach a copy of the statement showing the services provided. If a statement is not available, have the provider complete the Attending Physician's Statement in detail. **Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

**POLICYHOLDER & PATIENT INFORMATION**

NAME OF POLICYHOLDER		SOCIAL SECURITY NUMBER		OCCUPATION
ADDRESS		CITY	STATE	ZIP
E-MAIL ADDRESS		PHONE DAY ( )	FAX ( )	
		EVENING ( )		
NAME OF PATIENT		PATIENT'S SOCIAL SECURITY NUMBER	RELATIONSHIP TO POLICYHOLDER	PATIENT'S DATE OF BIRTH ____/____/____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, The Medical Information Bureau, or other organization, institution, or person, that has any records or knowledge of me or of any member of my family, or my (our) health, to furnish to National Teachers Associates Life Insurance Company of Addison, Texas or its representative, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. **I represent that the information above is true and correct.**

(Signed) Patient \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(Signed) Policyholder \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**ATTENDING PHYSICIAN'S STATEMENT**

Please have your physician/provider complete this section to indicate which of the following services were provided for the above-named patient. (This section does not need to be completed if you are attaching a detailed statement or bill which shows the exact procedure.)

For services relating to Cancer Policy:

**Cancer Screening Procedures**

- Mammogram Date: \_\_\_\_\_
- PAP Smear Date: \_\_\_\_\_
- Flexible sigmoidoscopy Date: \_\_\_\_\_
- Chest x-ray Date: \_\_\_\_\_
- Thermography Date: \_\_\_\_\_
- Colonoscopy Date: \_\_\_\_\_
- Blood test for colon cancer Date: \_\_\_\_\_
- Blood test for ovarian cancer Date: \_\_\_\_\_
- Blood test for prostate caner Date: \_\_\_\_\_

For services relating to Heart Attack, Heart Disease and Stroke Policy:

**Heart Screening Procedures**

- Resting EKG Date: \_\_\_\_\_
- Cardiovascular stress test Date: \_\_\_\_\_
- Lipid profile test Date: \_\_\_\_\_

**Heart Diagnostic Procedures**

- Holter Monitor Date: \_\_\_\_\_
  - Diagnostic cardiac catheterization Date: \_\_\_\_\_
  - Outpatient emergency room care Date: \_\_\_\_\_
- for the evaluation of cardiac symptoms

SIGNATURE OF PHYSICIAN	PHYSICIAN'S FEDERAL I.D. NUMBER	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
	PHYSICIAN'S SOCIAL SECURITY NUMBER	TELEPHONE NUMBER:
SIGNED _____ DATE _____	PATIENT'S ACCOUNT NUMBER	FAX NUMBER:
PRINT PHYSICIAN'S NAME		