Claimant's Statement
Cancer Insurance Only

☐ Conseco Life Insurance Company
☐ Philadelphia Life Insurance Company
☐ Wabash Life Insurance Company
P.O. Box 2012
Carmel, IN 46082-2012

CONSECO.

Policyowners Name	Policy No.	Telephone No.
Address	Date of Birth	☐ Male ☐ Female
	☐ Married ☐ Single ☐ Divorced ☐ Widowed	

1. If Claim is on a dependent, please give: _____
   Name
   Date of Birth _____ Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Common-law Spouse

   If Claim is on a dependent child over age 19 or 21 (depending on limiting age as described in your policy):

   A. Is child a full-time student? ☐ Yes ☐ No
   B. Is child physically handicapped? ☐ Yes ☐ No
   C. Is child mentally retarded? ☐ Yes ☐ No
   D. Is child married? ☐ Yes ☐ No

   If answer to A, B, C, or D is yes, complete documentation concerning the situation must be submitted with this claim form in order to establish a valid claim.

2. What is the nature of this illness? _____

3. What date were symptoms first noticed? _____

4. If hospitalized, give dates of confinement. _____

5. Please provide name and address of primary physicians:

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

6. Has claimant had cancer of any type in the past? ☐ Yes ☐ No If yes, please provide details of such illness and names and addresses of attending physicians. Please provide exact dates. Details:

   _____
   _____
   _____

   Name _____ Name _____ Name _____
   _____ _____ _____
   _____ _____ _____

7. Has claimant had a previous claim number? ☐ Yes ☐ No If yes, please provide claim number _____

We certify that the foregoing statements and answers are true and complete to the best of our knowledge and belief.

We hereby authorize any insurance company, prepayment organization, employer, union, trust fund, hospital, physician, druggist or any other person to release all information to the Life Insurance Company with respect to us or any of our dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. A photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Policyowner _____

Date _____ Signature of Spouse _____

Some states, including but not limited to Florida, Kansas, Kentucky, Minnesota, Ohio, and Oklahoma, require a statement such as the following:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or claim containing a false or deceptive statement is guilty of a crime.

CA: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name _____ Age _____

2. How long have you been the patient's doctor?

3. Diagnosis:

4. Is this tumor a metastasis of a previously diagnosed malignancy? (If yes, please send copies of pathology reports or clinical tests used in diagnoses.)

5. On what date did you first attend the patient for this condition?

6. On what date was the diagnosis of cancer first confirmed?

7. Has patient ever had cancer of any type in the past? ☐ Yes ☐ No

   If yes, give diagnosis and dates of treatment: _____

8. For the purpose of this claim form only, was the patient hospitalized? ☐ Yes ☐ No

   If yes, give dates confined: _____

   Type of treatment received: Definitive ☐ Palliative ☐ Surgical ☐ Chemotherapy ☐ Other ☐ Describe: _____

9. Please indicate the name and address of the referring physician and/or any other physicians who have treated the patient for cancer:

10. I do hereby certify the above statements are true and correct, to the best of my knowledge.

Date _____ Physician's Name (Please Print) _____

_____ Signature _____

Telephone

_____

Street Address

_____

City State Zip

Burba Insurance Services

Claude & Shirley Burba **P.O. Box 2127**
505-627-6175 **Roswell, New Mexico 88202**
Toll free (800) 894-9990 **Email: cburba@dfn.com**
Fax (505) 622-6052

FILING A CANCER CLAIM

To activate a cancer claim, the Policyholder should complete side one of the claim form, date and sign.

The attending physician should complete the back side of the claim form and date and sign.

Attach to the claim form a copy of your Pathologist's Report. Make copies of your claim form and path report for your records. Your originals should be mailed to us at the above address. We will forward your claim information to Conseco Variable Insurance Company.

Only one completed claim form is necessary. However when submitting itemized bills and mileage, please make sure your cancer policy number is printed at the top of each page and that you maintain copies. Bills can be mailed to us or mailed directly to:

Conseco Variable Insurance Co.
Cancer Claims
P.O. Box 2012
Carmel, IN 46082-2012

Should you have questions regarding your benefits or a claim filed, please call us at 1-800-894-9990 or 627-6175. Just as a reminder, please do not assign your benefits to any doctor or hospital.

Claude and Shirley Burba