“Serving you
- since ‘32”

OLD SURETY LIFE
INSURANCE COMPANY
P.O. BOX 54407 - OKLAHOMA CITY, OK 73154-1407
405-523-2112
Toll Free # 1-800-272-5466
Fax # 1-405-524-4011

HEARING, DENTAL & VISION CLAIM FORM

TO BE COMPLETED AND SIGNED BY THE PRIMARY INSURED.
(Please Print)

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

1. YOUR FULL NAME:____YOUR POLICY #:__________________
2. FULL NAME OF THE PERSON FOR WHOM YOU ARE REQUESTING BENEFITS
   ____ RELATIONSHIP_________________________
3. HAS THIS PERSON BEEN TREATED OR RECEIVED ADVICE FOR THIS CONDITION BEFORE? YES ☐ NO ☐
   IF “YES”, PLEASE LIST THE DATE(S) AND FROM WHOM: ____
4. WILL THE ATTACHED CLAIM BE COVERED BY ANY OTHER INSURANCE POLICY? YES ☐ NO ☐
   IF “YES”, PLEASE LIST THE POLICY # AND COMPANY: ____

*** **Complete the applicable section(s) below.** ***

FOR HEARING CLAIMS, please list the name(s) and address(es) of all doctors this person has seen during the past two (2) years for hearing conditions or problems:____
____

FOR DENTAL CLAIMS, please list the name(s) and address(es) of all dentists this person has seen during the past two (2) years for dental conditions or problems:____
____

FOR VISION CLAIMS, please list the name(s) and address(es) of all optometrists and/or ophthalmologists this person has seen during the past two (2) years for vision conditions or problems:____
____

AUTHORIZATION: I hereby authorize any physician, hospital, insurance company, employer or any other organization that has any records or knowledge of my medical history or the medical history of the above listed dependent, to provide to OLD SURETY LIFE INSURANCE COMPANY or its reinsurers, any such information.

I understand that this information may include information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

I understand that a photocopy of this authorization shall be as valid as the original and that this authorization shall remain valid for up to twenty-four (24) months unless revoked in writing by me to the home office of Old Surety Life Insurance Company.

____ ____________________
Your Signature Date