

East Texas Employee Cooperative  
American Public Life – Group #12583  
Guidelines for Submitting a Cancer Diagnostic Testing Benefit Claim  
(One \$50 Benefit per covered person per calendar year. Please refer to your certificate of insurance for a list of covered tests and further details regarding this benefit.)

Fill in the following information. Attach a copy of the bill showing the charge for the cancer screening test performed. Submit the claim by faxing both this cover sheet and the copy of the bill to the Claims Department at American Public Life at 601-939-4495 or by mailing it to Claims Department, American Public Life, P. O. Box 925, Jackson, MS 39205-0925. Should you have any questions, the company's toll-free number is 800-256-8606.

Primary Insured \_\_\_\_\_

SSN or Certificate Number \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Name of Patient \_\_\_\_\_

Date of Service \_\_\_\_\_