USAble Life

HOSPITAL CONFINEMENT PLAN

INSTRUCTIONS FOR FILING CLAIMS

Please complete the following information related to your Hospital Confinement Plan (HCP) claim. This information is required in order to process your claim, without delay.

Insured's Name _____

Insured's Date of Birth _____

Insured's Social Security Number _____

Insured's Employer _____

Insured's Mailing Address _____

Street or P.O. Box

_____

City **State** **Zip Code**

Patient's Name _____

Patient's Relation to Insured _____

Patient's Date of Birth _____

Patient's Social Security Number _____

Diagnosis (reason for hospital confinement) _____

_____

Enclose a copy of the hospital bill showing number of days in the hospital.

Mail the above information to:

Claims Department
USAble Life
P.O. Box 1650
Little Rock, AR 72203

If you have any questions about how to submit your claim, please call:
(501) 375-7200 or 1-800-648-0271