

P.O. Box 7725, San Francisco, CA 94120 1-888-800-2742

## Dismemberment Claim Form for Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

NOTE: Please complete the entire claim form. This form cannot be processed if information is incomplete.

IMPORTANT: PLEASE PRINT USING INK.

**IMPORTANT NOTICE: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.**

### STATEMENT OF CLAIMANT

FULL NAME				TELEPHONE NO. (    )	
ADDRESS (NUMBER, STREET, APARTMENT)			CITY	STATE	ZIP
BIRTHDATE (mo/day/yr)		SOCIAL SECURITY NO.	AGE	OCCUPATION	
DATE OF ACCIDENT	DID YOUR ACCIDENT HAPPEN "ON THE JOB?" <input type="checkbox"/> Yes <input type="checkbox"/> No		HAVE YOU BEEN HOSPITAL CONFINED? <input type="checkbox"/> Yes <input type="checkbox"/> No		
NAME OF HOSPITAL					
STREET ADDRESS OF HOSPITAL			CITY	STATE	ZIP
DATE CLAIMANT ENTERED HOSPITAL		DATE RELEASED FROM HOSPITAL			

**These statements are true and complete to the best of my knowledge. I authorize any insurer, physician or hospital to disclose any information regarding my insurance coverage or medical history. A photocopy of this form will be as valid as the original.**

Signed: **X** \_\_\_\_\_ DATED \_\_\_\_\_, 20\_\_\_\_

### STATEMENT OF EMPLOYER/GROUP POLICYHOLDER

GROUP NAME					
GROUP POLICY NO.			GROUP EFFECTIVE DATE		
CLAIMANT'S LAST DAY WORKED		DATE CLAIMANT WAS EMPLOYED		CLAIMANT'S INSURANCE EFFECTIVE DATE	
BASIC LIFE INSURANCE AMOUNT \$		AMOUNT OF BENEFIT REQUESTED \$		ANNUAL SALARY (if benefit is salary based) \$	
IS CLAIMANT'S INSURANCE STILL IN EFFECT? <input type="checkbox"/> Yes <input type="checkbox"/> No		WAS CLAIMANT'S INSURANCE IN EFFECT ON THE DAY OF THE ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		IS CLAIMANT STILL EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### SIGNATURE

Signed: <b>X</b> _____ DATED _____, 20____					
TITLE			TELEPHONE NO.		
STREET ADDRESS			CITY	STATE	ZIP

**ATTENDING PHYSICIAN'S STATEMENT**

NAME OF CLAIMANT	DATE OF BIRTH
------------------	---------------

PLEASE IDENTIFY THE LOSS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ ICD CODE (if known) \_\_\_\_\_

IS THE LOSS PERMANENT AND IRRECOVERABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No	WAS THE LOSS CAUSED BY AN ACCIDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

DIAGNOSIS (including any complications)

\_\_\_\_\_

\_\_\_\_\_

OBJECTIVE FINDINGS

\_\_\_\_\_

\_\_\_\_\_

PATIENT'S CONDITION

Recovered  Improved  Retrogressed  Unchanged  Ambulatory  Hospital Confined  Bed Confined  House Confined

DATE OF FIRST VISIT	DATE OF LAST VISIT
---------------------	--------------------

FREQUENCY OF VISITS:

Weekly  Twice Monthly  Monthly  As Needed  Other (specify): \_\_\_\_\_

WHEN DID ACCIDENT HAPPEN OR SYMPTOMS FIRST APPEAR?	IS PATIENT ABLE TO WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION?  
 Yes  No If YES, when? \_\_\_\_\_

HAS PATIENT BEEN HOSPITALIZED FOR THIS CONDITION?  
 Yes  No If YES, when? \_\_\_\_\_

NAME OF HOSPITAL

ADDRESS	CITY	STATE	ZIP
---------	------	-------	-----

DATE PATIENT ENTERED THE HOSPITAL

DATE RELEASED FROM HOSPITAL

<b>ATTENDING PHYSICIAN</b> (please print) NAME	TELEPHONE NO. (    )
---	-------------------------

ADDRESS	CITY	STATE	ZIP
---------	------	-------	-----

SPECIALTY/DEGREE	DATE
------------------	------

SIGNATURE

**X** \_\_\_\_\_