

# STATEMENT OF CLAIM

## FOR ACCIDENTAL DISMEMBERMENT BENEFITS

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

### TO BE COMPLETED BY THE EMPLOYEE

(Please answer all questions)

- Employee's name (print) \_\_\_\_\_ Age \_\_\_\_\_  
Employee Social Security # \_\_\_\_\_
- Employee phone number with area code \_\_\_\_\_
- Present Address \_\_\_\_\_  
(Number) (Street) (City) (State) (Zip Code)
- When did the accident happen? Date \_\_\_\_\_ YR \_\_\_\_\_ at \_\_\_\_\_  
(Hour) { a.m. / p.m. }
- Where did the accident happen? City \_\_\_\_\_ State \_\_\_\_\_
- Give a brief description of the accident \_\_\_\_\_  
\_\_\_\_\_
- Please attach (a) copy of your accident report and any newsletter clippings giving details of the accident.  
(b) copy of the toxicology report if you were the driver in a motor vehicle accident.

I authorize the physician to release any information requested with respect to this Claim.

I certify that the information I furnished to support this claim is true and correct. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

Date \_\_\_\_\_ YR \_\_\_\_\_ Signed \_\_\_\_\_  
(Insured Employee)

### TO BE COMPLETED BY THE EMPLOYER

(Please answer all questions)

- Employee's name \_\_\_\_\_ Certificate No. \_\_\_\_\_ Group No. \_\_\_\_\_
- Amount of Accidental Dismemberment Benefit, (Full) \$ \_\_\_\_\_ Half \$ \_\_\_\_\_ Issued Date \_\_\_\_\_ YR \_\_\_\_\_
- If this coverage has been canceled, give the date and reason \_\_\_\_\_
- (a) Date last worked \_\_\_\_\_ YR \_\_\_\_\_  
(b) Date returned to work \_\_\_\_\_ YR \_\_\_\_\_
- Has this claim been considered in connection with worker's compensation coverage?  Yes  No  
If "Yes", what is the present status of the compensation claim? \_\_\_\_\_
- Give any information which might assist the Company in consideration of this claim. \_\_\_\_\_  
\_\_\_\_\_
- Please attach (a) copy of the employee's insurance record cards.

Date \_\_\_\_\_ YR \_\_\_\_\_  
Employer \_\_\_\_\_  
(Name and Address) (Phone - Area Code and No.)

Signed by \_\_\_\_\_

Title \_\_\_\_\_

**IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE OUT FACTS YOU KNOW ARE IMPORTANT.  
TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

1. Name of patient \_\_\_\_\_ Age \_\_\_\_\_

2. (a) Date first consulted on account of the injury described \_\_\_\_\_ YR \_\_\_\_\_

(b) Date of last treatment \_\_\_\_\_ YR \_\_\_\_\_

3. Describe the exact nature, location, and extend of all injuries sustained \_\_\_\_\_

**TO BE COMPLETED ONLY FOR LIMB AMPUTATIONS**

4. (a) Which limbs were severed or amputated?

(b) State the dates on which the severances or amputations occurred.

(c) State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

5. State the cause of the amputations.

6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated, or examined.

7. Please give the names of such other physicians as have attended this patient, and the dates of their first and last treatments as reported to you.

**TO BE COMPLETED ONLY FOR LOSS OF VISION**

4. Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

(a) Date \_\_\_\_\_

(b) (Snellen Notations)

O.D.v.	Uncorrected	Corrected
O.S.v.		

5. Give the date and vision found on last eye examination.

(a) Date \_\_\_\_\_

(b) (Snellen Notations)

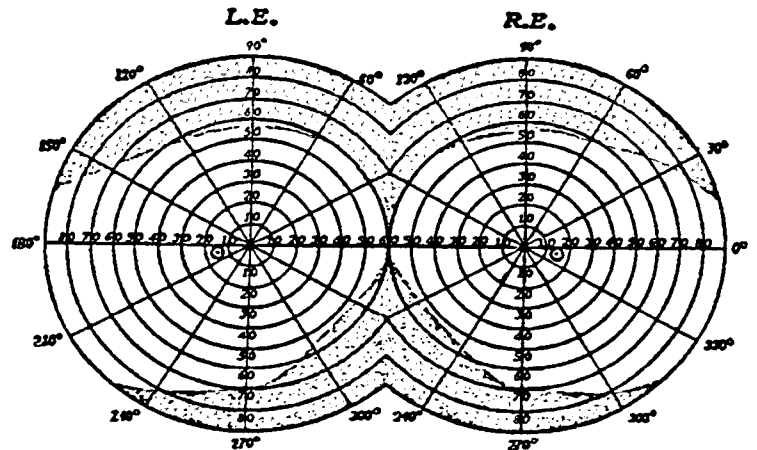
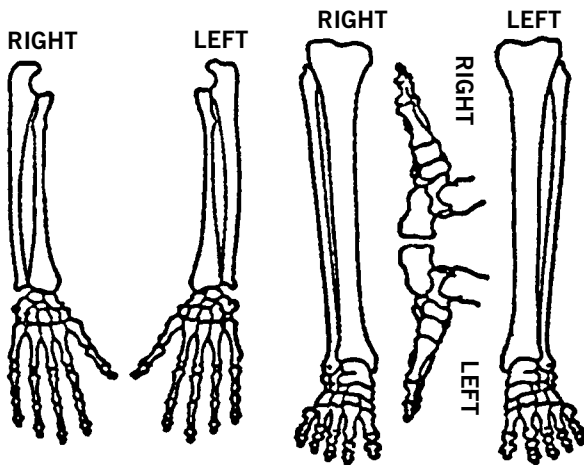
O.D.v.	Uncorrected	Corrected
O.S.v.		

6. State the cause of loss of vision

7. Indicate whether recovery or useful vision is possible by operation or treatment.

O.D.  Operation  Treatment  
O.S.  Operation  Treatment

7a. If fields of vision are contracted, show contraction on chart below.



8. (a) Was the injury described solely responsible for the loss? \_\_\_\_\_

(b) If not, give the particulars of any contributing cause or causes \_\_\_\_\_

Signed \_\_\_\_\_ (Attending Physician)

Address \_\_\_\_\_

Date \_\_\_\_\_ YR \_\_\_\_\_

Phone No. \_\_\_\_\_