

DISMEMBERMENT CLAIM FORM

By furnishing this form and investigating the claim, the Company does not admit liability and does not waive its rights or defenses



FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Part I TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR

Group Policy Number		Certificate Number		Social Security Number	
1. Name of Insured			Job Title		Last Date at Work
2. Address				Date of Birth	Month Day Year
3. Insurance Classification		Effective date of last increase in benefits		Has insurance been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Full amount of AD&D insurance \$		Amount of this claim \$		<input type="checkbox"/> 100% <input type="checkbox"/> 50%	
5. Is loss due to an occupational accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes," has Workers' Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Name of Workers' Compensation carrier			Address		
7. Do you recommend payment of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		Remarks			
Date	Name of Group Policyholder			By	Title

Part II TO BE COMPLETED BY EMPLOYEE OR MEMBER

1. Date of Accident		Hour of Accident <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		Place of Accident	
2. Describe what happened			What injuries were sustained?		
3. Was immediate First Aid sought? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes," please list below:			
Name and Address of Doctor		Name and Address of Hospital		Name and Address of Other Medical Facility	
4. Was accident reported to police or other official agency? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes," name and address of official agency			
5. Name and address of witnesses					
6. Do you have other insurance providing dismemberment or loss of sight benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			If "Yes," name of other carrier		Policy No.
7. Name of auto insurance carrier, if loss is due to auto accident					
I hereby authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company or other person, organization, or institution, that has any records or knowledge of any illness or injury I may have suffered, to give to Companion Life Insurance Company, or its representative, any such information. A photocopy of this authorization shall be as valid as the original.					
Date	Signature of Employee or Member				

Part III ATTENDING PHYSICIAN'S STATEMENT/REVERSE OF FORM

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient _____
1. On what date were you first consulted for the condition described in the claimant's statement? _____
2. What history were you given on the initial visit as to the cause of the condition? _____ _____
3. Of what symptoms did the patient complain? _____ _____
4. Was there visible evidence of trauma? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please describe _____
5. Please describe any other findings revealed by your examination. _____ _____
6. Was there any indication that disease might have caused or contributed to the loss? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain _____

COMPLETE ONLY THE APPROPRIATE SECTION

LOSS OF LIMB	<p>A. State which member is affected</p> <p><input type="checkbox"/> Right hand <input type="checkbox"/> Right foot <input type="checkbox"/> Finger or Thumb</p> <p><input type="checkbox"/> Left hand <input type="checkbox"/> Left foot <input type="checkbox"/> Identify which _____</p> <p>B. Point of amputation _____ Is this above the wrist or ankle (or the metacarpal-phalangeal joint for fingers)?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Date of amputation _____</p> <p>D. In your opinion did amputation result solely from accidental bodily injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
LOSS OF SIGHT	<p>A. Visual acuity: with glasses OD _____ OS _____ Date _____</p> <p style="padding-left: 100px;">without glasses OD _____ OS _____ Date _____</p> <p>B. Can vision be improved by treatment or lens? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. In your opinion is loss of sight complete and irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. In your opinion is loss of sight due solely to accidental bodily injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Is there a total loss of vision, when did such loss occur? _____</p>

Date	Signature of Physician	Address	Phone
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