



333 Westchester Avenue • White Plains, NY 10604-2910 • 914-367-5000

**STATEMENT OF CLAIM  
FOR  
ACCIDENTAL DISMEMBERMENT BENEFITS**

**TO BE COMPLETED BY THE INSURED**  
*(Please answer all questions)*

- 1. Insured's name (Print) \_\_\_\_\_  
Phone No. (area code and number) ( ) \_\_\_\_\_ Age \_\_\_\_\_
- 2. Present Address \_\_\_\_\_  
(Number) (Street) (City) (State) (Zip)
- 3. When did the accident happen? Date \_\_\_\_\_ 20 \_\_\_\_\_ at \_\_\_\_\_ a.m.  
p.m.
- 4. Where did the accident happen? City \_\_\_\_\_ State \_\_\_\_\_
- 5. Give a brief description of the 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.**

**NEW YORK RESIDENTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AND APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. FOR RESIDENTS OF ALL OTHER STATES, PLEASE SEE THE LAST PAGE OF THIS FORM.

Date \_\_\_\_\_ 20 \_\_\_\_\_ Signed \_\_\_\_\_  
(Insured Employee)

**TO BE COMPLETED BY THE GROUP**  
*(Please answer all questions)*

- 1. Insured's name \_\_\_\_\_ Certificate No. \_\_\_\_\_ Group No. \_\_\_\_\_
- 2. Branch No. \_\_\_\_\_ Sub Code No. \_\_\_\_\_
- 3. Amount of Accidental Dismemberment Benefit, (Full) \$ \_\_\_\_\_ (Half) \$ \_\_\_\_\_ Issue Date \_\_\_\_\_ 20 \_\_\_\_\_
- 4. If this coverage has been canceled, give the date and reason \_\_\_\_\_
- 5. (a) Date last worked \_\_\_\_\_ 20 \_\_\_\_\_  
(b) Date returned to work \_\_\_\_\_ 20 \_\_\_\_\_
- 6. Has this claim been considered in connection with workers' compensation coverage?  Yes  No  
If "Yes", what is the present status of the compensation claim? \_\_\_\_\_
- 7. Give any information which might assist the Company in the consideration of this claim \_\_\_\_\_
- 8. Please attach (a) copy of your accident report and any newspaper clippings giving details of the accident.  
(b) copy of this insured's insurance record cards.

Date _____ 20 _____	
Group _____ (Name & Address)	(Phone - Area Code & No.) _____
Signed By _____	Title _____

## TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Name of patient \_\_\_\_\_ Age \_\_\_\_\_
2. (a) Date first consulted on account of the injury described \_\_\_\_\_ 20 \_\_\_\_\_  
 (b) Date of last treatment \_\_\_\_\_ 20 \_\_\_\_\_
3. Describe the exact nature, location and extent of all injuries sustained \_\_\_\_\_

TO BE COMPLETED ONLY FOR LIMB AMPUTATIONS	TO BE COMPLETED ONLY FOR LOSS OF VISION												
<p>4. (a) Which limbs were severed or amputated?</p> <hr/> <p>(b) State the dates on which the severances or amputations occurred.</p> <hr/> <p>(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.</p> <hr/> <p>5. State the causes of the amputations.</p> <hr/> <p>6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated or examined.</p> <hr/> <p>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.</p>	<p>4. Give the date you first determined vision was irreversibly reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each.</p> <p>(a) Date _____</p> <p>(b) (Snellen Notations)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">O.D.v.</td> <td style="width: 33%;">Uncorrected</td> <td style="width: 33%;">Corrected</td> </tr> <tr> <td>O.S.v.</td> <td></td> <td></td> </tr> </table> <hr/> <p>5. Give the date and vision found on last eye examination.</p> <p>(a) Date _____</p> <p>(b) (Snellen Notations)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">O.D.v.</td> <td style="width: 33%;">Uncorrected</td> <td style="width: 33%;">Corrected</td> </tr> <tr> <td>O.S.v.</td> <td></td> <td></td> </tr> </table> <hr/> <p>6. State the causes of loss of vision.</p> <hr/> <p>7. Indicate whether recovery of useful vision is possible by operation or treatment.</p> <p>O.D.      <input type="checkbox"/> Operation      <input type="checkbox"/> Treatment</p> <p>O.S.      <input type="checkbox"/> Operation      <input type="checkbox"/> Treatment</p> <hr/> <p>7. (a) If fields of vision are contracted, show contraction on chart below.</p> <div style="text-align: center;"> </div>	O.D.v.	Uncorrected	Corrected	O.S.v.			O.D.v.	Uncorrected	Corrected	O.S.v.		
O.D.v.	Uncorrected	Corrected											
O.S.v.													
O.D.v.	Uncorrected	Corrected											
O.S.v.													

8. (a) Was the injury described solely responsible for the loss? \_\_\_\_\_
- (b) If not, give the particulars of any contributing cause or causes \_\_\_\_\_

Signed \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_ 19 \_\_\_\_\_

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

## FRAUD WARNINGS FOR CLAIM FORMS

**Arkansas, Louisiana, Massachusetts, New Mexico, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine, Tennessee, Virginia and Washington Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Delaware, Florida, Idaho and Indiana Residents:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Alaska Residents:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under the law.

**Arizona Residents:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

**Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of Insurance within the department of regulatory agencies.

**District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota Residents:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire Residents:** Any person who, with a purpose to injure or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638.20.

**New Jersey Residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

**Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Texas Residents:** 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 state prison.