STATEMENT OF CLAIM
FOR
ACCIDENTAL DISEMBEMENT 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 ____________________________________________________________ Age __________________________

3. When did the accident happen? Date ___________________________ 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 MATERIALY 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 __________________________

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 ________________________________________________________________

Signed By ___________________________________________ Title __________________________

Form #3547
A member of the Amalgamated Family of Companies
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 ______________________

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<th>TO BE COMPLETED ONLY FOR LIMB AMPUTATIONS</th>
<th>TO BE COMPLETED ONLY FOR LOSS OF VISION</th>
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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 causes 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.

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

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

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Signed ____________________________
Address ____________________________

Date ____________________________ 19 ______ Phone No. ____________________________
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.

August 2012