



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. \_\_\_\_\_