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.
(Hour)

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 ______________________________

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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** ______________

Form #3547

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

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.

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.

(a) Date ____________________

(b) (Snellen Notations)

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

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

(a) Date

(b) (Snellen Notations)

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

6. State the causes of loss of vision.

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

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

7. (a) 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 ____________________

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____

Signed ____________________

Address ____________________

____

Date ____________________ 19 ______

Phone No. ____________________