

PART C: CLAIMANT INFORMATION

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY) DESCRIBE INJURIES RECEIVED.

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED EMPLOYEE/MEMBER FOR THESE INJURIES

Table with 3 columns: NAME, ADDRESS, PHONE NUMBER. Two rows for listing physicians.

LIST ALL WITNESSES TO ACCIDENT

Table with 3 columns: NAME, ADDRESS, PHONE NUMBER. Two rows for listing witnesses.

HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

FOR RESIDENTS OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Signature and address fields for claimant or authorized representative. Includes fields for date signed, business phone number, and home phone number.

PART D: ATTENDING PHYSICIAN'S STATEMENT

THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION OF THIS STATEMENT WITHOUT EXPENSE TO THE COMPANY.

Fields for patient name, age, and address (street, city, state, zip code).

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

Fields for when accident happened (month, day, year) and when patient first consulted you for this condition (month, day, year).

Table for injury details: DID THE ACCIDENTAL INJURY RESULT IN: LOSS OF HANDS?, LOSS OF THUMB AND INDEX FINGER OF SAME HAND?, LOSS OF FEET?, TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS? Includes checkboxes for right/left, severance, and date of loss.

IN YOUR OPINION, WAS ANY DISEASE, INFECTION, BODILY OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?
IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION? YES NO

IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGHT, PLEASE ANSWER THE FOLLOWING QUESTIONS:
IF THE LOSS OF SIGHT IS PARTIAL, BUT IRRECOVERABLE, PLEASE STATE AMOUNT OF VISION IN EACH EYE WITH SNELLEN NOTATIONS, OR JAEGER SCALE, IF PERTINENT.
UNCORRECTED CORRECTED DATE OF EXAMINATION
O.D. O.S. O.D. O.S.

DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR OPERATION? YES NO
IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE.
WAS PATIENT CONFINED TO A HOSPITAL? YES NO IF "YES," GIVE NAME AND ADDRESS OF HOSPITAL.

TREATMENT
DATE OF FIRST VISIT DATES OF SUBSEQUENT VISITS
SIGNATURE OF ATTENDING PHYSICIAN PHYSICIAN'S NAME (PLEASE PRINT) DEGREE TELEPHONE DATE
STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES NO

IF DISCHARGED, GIVE DATE OF DISCHARGE: