

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.

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

Form for signature and address. Includes fields for SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE, DATE SIGNED (MONTH, DAY, YEAR), ADDRESS OF CLAIMANT, BUSINESS PHONE NUMBER, HOME PHONE NUMBER.

PART D: ATTENDING PHYSICIAN'S STATEMENT

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

Table with 3 columns: NAME OF PATIENT, AGE, ADDRESS (STREET, CITY, STATE, ZIP CODE).

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

Table with 2 columns: WHEN DID ACCIDENT HAPPEN? (MO., DAY, YEAR), WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MO., DAY, YEAR)

DID THE ACCIDENTAL INJURY RESULT IN:

Table for injury details. Rows include: LOSS OF HANDS?, LOSS OF THUMB AND INDEX FINGER OF SAME HAND?, LOSS OF FEET?, TOTAL AND IRRECOVERABLE RIGHT EYE, LOSS OF SIGHT OF: LEFT EYE, TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS?. Columns include: YES/NO checkboxes, DATE OF SEVERANCE, EXTANT OF SEVERANCE, DATE OF LOSS, WAS EYE REMOVED?, DATE REMOVED.

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

Table for treatment details. Includes: 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: