



Attention: Claims Department
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone (501) 378-5856

Statement of Claim Group Accident Insurance

Please type or print in blue or black ink.

| | |
|-------------------|-------|
| For H.O. Use Only | |
| Eff | _____ |
| PTD | _____ |
| Benefits | _____ |

Important: Read Carefully

This form should be completed by the attending physician and by the claimant upon the death or loss by an insured employee or dependent and should be forwarded to US Able Life. It will be necessary to furnish a copy of the investigating officer's report for loss due to suicide, homicide or motor vehicle accident. An official Certified Death Certificate is also required for loss of life claims. By furnishing this form and investigating this claim, US Able Life shall not be held to admit the validity of any claim or to waive or breach any condition of the policy.

CLAIMANT'S STATEMENT

| | | | | |
|--|--------------------------------------|---|--|--|
| Name of Insured | | Social Security # | Age | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Address (Number and Street) (City, State) (Zip) | | Daytime Telephone Number () | | |
| Name of Person Suffering Loss of Life, Limb or Sight | Date of Birth | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Relation to Insured | |
| Home Address (Number and Street) (City, State) (Zip) | | | | |
| Loss Suffered <input type="checkbox"/> Loss of Life (attach Certificate of Death) <input type="checkbox"/> Loss of Limb <input type="checkbox"/> Loss of Sight <input type="checkbox"/> Loss of Thumb & Index Finger | | | | |
| Name of Claimant | Date of Birth | Relation to Insured | Claimant Is: <input type="checkbox"/> Beneficiary <input type="checkbox"/> Insured <input type="checkbox"/> Other | |
| Home Address (Number and Street) (City, State) (Zip) | | Daytime Telephone Number () | | |
| Where Injury Happened (Street, City, State) | When Injury Happened (Date and Time) | | Date of Death (if applicable) | |
| How Injury Happened | | | | |
| Other Accidental Death or Dismemberment Ins. <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of Insurance Company | Address (City, State) | Policy No. | Amount of Insurance |

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to US Able Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

FRAUD WARNING: Except as noted in separate Fraud notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date: _____ Signature of Claimant _____
(Parent/Guardian if Minor)

EMPLOYER'S STATEMENT

| | | | | | | |
|--|---|---|---|--|-----------------|------------|
| Full Name of Insured | | Age | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status | Certificate No. | Policy No. |
| Name of Person Suffering Loss of Life, Limb or Sight | | Occupation | Age | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status | |
| Date Insurance Became Effective on Such Person | Amount of Insurance in Force on Such Person | Was Loss Due to an Occupational Accident? | Date of Death or Dismemberment | Was Insurance in Effect on Date of Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Name of Beneficiary (if death claim) | | Social Security # | Date of Birth | Relationship to Deceased | | |
| Is Beneficiary a Minor? If So, Give Full Name and Address of Guardian. (Certified copy of court order appointing guardian must be attached.) | | | | | | |

The following line is to be completed ONLY if the employee is the person suffering loss.

| | | | | |
|--|---------------------------|---|----------------------------|--|
| Date Hired | Date Employee last worked | Reason for Stopping Work <input type="checkbox"/> Illness <input type="checkbox"/> Layoff <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retired <input type="checkbox"/> Other (explain) | Date Employment Terminated | Was Employee <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried |
| Name of Policyholder/Employer | | Address | | Telephone |
| Name of Authorized Representative (Please Print) | | Signature | | Date Signed |

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ATTENDING PHYSICIAN'S STATEMENT

Section I - Please complete this section if claim is for loss of life. If loss of sight/dismemberment, complete Section II below.

| | | | |
|--|--|---------------|------------------|
| Name of Deceased | | Age at Death | |
| Residence at Time of Death (Number and Street) | | (City, State) | (Zip) |
| Date of Death | Place (if in hospital or institution, give name) | | |
| Immediate Cause of Death (Include ICD Codes) | | | |
| Was Death Due To <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Illness <input type="checkbox"/> Accidental Bodily Injury | | | |
| If Injury, Give Details and Date | | | |
| Were there any contributing causes of death? Give the dates and duration of each as closely as you can. | | | |
| Was there an autopsy, inquest, or post mortem examination? By whom? | | | |
| I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. | | | |
| Physician's Signature | | | Date |
| Physician's Name | | | Degree |
| Address | | | Telephone () |
| City | State | Zip | Fax () |

Section II - This portion is to be completed if the claim is for loss of sight or dismemberment.

| | | | |
|--|---|---|--|
| Name of Patient | | Date of Birth | |
| Home Address (Number and Street) | | (City, State) | (Zip) |
| Nature of Injury (Include ICD Codes) | | When Did It Occur? | |
| If loss of limb, was it through or above wrist or ankle joint? <input type="checkbox"/> Yes <input type="checkbox"/> No | If loss of thumb and index finger, is it above the metacarpophalangeal joint? <input type="checkbox"/> Yes <input type="checkbox"/> No | If loss of sight, is it entire and irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, on what date did it become so? |
| Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain: | | | |
| Were any surgical procedures involved? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Describe: | | | Date Performed |
| I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. | | | |
| Physician's Signature | | Provider ID # | Date |
| Physician's Name | | Degree | |
| Address | | Telephone () | |
| City | State | Zip | Fax () |

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: Any person who knowingly presents 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.

Colorado: 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.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania: 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.