USAble Life

Statement of Claim
Group Accident Insurance

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

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

Important: Read Carefully

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a claim for insurance may be guilty of a crime and subject to fines and confinement in prison.

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 USAble 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, USAble 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 ☐ Male ☐ 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 ☐ Male ☐ Female	Relation to Insured

Home Address (Number and Street) (City, State) (Zip)

Loss Suffered ☐ Loss of Life (attach Certificate of Death) ☐ Loss of Limb ☐ Loss of Sight ☐ Loss of Thumb & Index Finger

Name of Claimant	Date of Birth	Relation to Insured	Claimant Is: ☐ Beneficiary ☐ Insured ☐ 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. ☐ Yes ☐ No	Name of Insurance Company Address (City, State) Policy No. Amount of Insurance

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 USAble 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.

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

EMPLOYER'S STATEMENT

Full Name of Insured	Age	Sex ☐ Male ☐ Female	Marital Status	Certificate No.	Policy No.

Name of Person Suffering Loss of Life, Limb or Sight	Occupation	Age	Sex ☐ Male ☐ 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? ☐ Yes ☐ 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 ☐ Illness ☐ Layoff ☐ Leave of Absence ☐ Retired ☐ Other (explain)	Date Employment Terminated	Was Employee ☐ Full-time ☐ Part-Time ☐ Hourly ☐ Salaried

Name of Policyholder/Employer	Address	Telephone

Name of Authorized Representative (Please Print)	Signature	Date Signed

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 ☐ Suicide ☐ Homicide ☐ Illness ☐ 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**

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? ☐ Yes ☐ No	If loss of thumb and index finger, is it above the metacarpophalangeal joint? ☐ Yes ☐ No	If loss of sight, is it entire and irrecoverable? ☐ Yes ☐ 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? ☐ Yes ☐ No
If No, please explain:

Were any surgical procedures involved? ☐ Yes ☐ 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**