Overview of Accidental Dismemberment Claim Form for EMPLOYEE

To the Employer and Employee/Beneficiary:

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Please take note of the Fraud Notice that follows.

**Fraud Notice:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fine and confinement in prison.

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The information below constitutes a complete claim filed with HealthChoice for purposes of claiming dismemberment benefits.

**PART I – Employer’s Statement**
- Form is to be completed in its entirety and signed by the official representative of the employer/plan.
- Proof of salary as defined in the policy (attach commission, if applicable).
- Submission of claims on any voluntary or contributory life plan, and copies of the enrollment forms and history to show timely enrollment.

**PART II – Claimant’s Statement**
- Must be completed by claimant or insured claiming any dismemberment due to an accident.
- Additionally, please furnish any police or motor vehicle reports, toxicology or other pertinent information regarding the claim for accidental dismemberment or injury.

**Part III – Attending Physician’s Statement**
- For dismemberment
- For loss of sight
- For loss of hearing
- For loss of speech

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.
Dismemberment Claim Form

To avoid a delay or denial of benefits, please complete all applicable questions and submit medical records, supporting accident reports and toxicology reports documenting the accidental injury.

EMPLOYEE STATEMENT (To be completed by employee or member)
Employee Name: ____________________________________________________________

Address: __________________________________________________________________________
City: __________________ State: ______ ZIP: ______ Email Address: _____________________________
Date of Birth: _______________ Home Phone: ___________________ Cell Phone: ___________________
SSN: ____________________ Occupation: ________________________________

Benefit Claimed: □ Loss of hand □ Loss of foot □ Loss of eye □ Quadriplegic □ Paraplegic
□ Hemiplegic □ Loss of two or more members □ Other ________________________________

Total Group Accidental Life: Basic AD&D _______ Opt AD&D _______ Vol AD&D _______
Benefit amount: Basic AD&D _______ Opt AD&D _______ Vol AD&D _______

INJURY STATEMENT
Name of Person Injured: _________________________________________________________

Date of Birth: _______________ Age: __________
Social Security Number: __________________________ Occupation: ___________________________
Date of Accident: ___________________ Did the accident happen on the job? □ Yes □ No
Did this accident occur during the participation of a hobby that may be deemed hazardous?
□ Yes □ No

Briefly Describe the Accident: ____________________________________________________
Physician Name: ___________________________________ Specialty: _______________________
Physician Address: ___________________________________________________________________
Hospital Name: ____________________________
Hospital Address: _______________________________
Hospital Phone: ___________________________ Hospital Fax: ____________________________

These statements are true and complete to the best of my knowledge. I have completed and
attached the Authorization for Release of Information. A photostatic copy of this form will be as valid
as the original.

Signature of Employee: ___________________________________ Date: _______________________

Please also complete Authorization for Release of Information contained in this packet.

Payment Method □ Direct Deposit Financial Institution’s Name: ____________________________
Type of Account □ Checking Bank/Routing Number: __________________________
Checking Account Number: _________________________________
Dismemberment Claim

EMPLOYER’S STATEMENT (To be completed by the employer)

Group Name:__________________________________________________________

Group Plan Number:____________________________________________________

Phone:________________________ Fax:________________________ Email:________________________

Employee Hire Date:________________________ Effective Plan Coverage Date:________________________

Employee Status:________________________ Plan ID:________________________

Did the Employee Elect?

Basic Life Coverage Plan: □ Yes □ No

Supplemental Life Coverage: □ Yes □ No

Amount of Benefit: AD&D under Basic Life Coverage $________________________

Was the employee still employed on date of accident? □ Yes □ No

Amount of Benefit: AD&D under Basic Supplemental Life Coverage $________________________

Was the employee still employed on date of accident? □ Yes □ No

Print Name:_________________________________________ Title:_________________________________________

Signature:_________________________________________ Date:_________________________________________
Authorization For Release of Information

I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility, insurance, government agency, department of labor, law enforcement or public safety department, group policyholder; employer; or policy or benefit plan administrator to release information from the records of Claimant/Insured:

First: ___________________________ MI: _______ Last: ___________________________

Date of Birth: ___________________________ Social Security Number: ___________________________

1. Claimant Information to be released:
   ● Data or records regarding medical history, treatment, prescriptions, consultations, (including medical and psychological reports, records, charts, notes [excluding psychotherapy notes], X-rays films or correspondence, and any medical condition(s)).
   ● Any information regarding insurance coverage.
   ● Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).

2. Information to be released to: HealthSCOPE Benefits
   P.O. Box 2338
   Little Rock, AR 72203.

   HealthSCOPE Benefits is the administrator of HealthChoice Life Insurance Plan.

3. I understand the information obtained by use of the authorization will be used by HealthSCOPE Benefits (Company) to evaluate my claim for dismemberment/plegia benefits. The Company will only release such information:
   ● To other persons or organizations performing business or legal services in connection with my claims(s);
   ● As otherwise may be required by law or as I may further authorize.

   I further understand that refusal to sign this authorization may result in the denial of benefits.

4. I understand that I may revoke this authorization in writing at any time, except to the extent:
   1. The Company has taken action in reliance on this authorization.
   2. The Company is using this authorization in connection with a contestable claim.

If written revocation is not received, this authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this authorization, direct all correspondence to the Company at the above address.

5. A photocopy of this authorization is to be considered as valid as the original.

6. I understand I am entitled to receive a copy of this authorization.

SIGNATURE: ___________________________________________ DATE: _______________
PRINT NAME: ___________________________________________ PHONE: _______________

Relationship to claimant for personal/legal representative signing for claimant.

Power of attorney or guardianship must be attached.
Name of Employee: ___________________________ Employer’s Name: ___________________________

Attending Physician’s Statement

1. Name of patient: (First, MI Last) ___________________________ Age: __________________
2. Date of accident causing present loss: (Month, Day, Year) ___________________________
3. Date first consulted on account of the injury described: ___________________________
4. Date of last treatment for this condition: (Month, Day, Year) __________________________
5. Describe the exact nature, location and extent of all injuries sustained: __________________________
6. Was the injury described solely responsible for the loss? □ Yes □ No
   If not, give the particular of any contributing cause or causes. __________________________
7. Names of any other physicians who treated the patient for a contributory condition and the dates of their first and last treatments as reported to you __________________________
8. In your opinion, was the loss caused in any way by illness? □ Yes □ No
   If yes, what was the date you provided treatment for the illness? __________________________
9. Did the patient ever consult you before? □ Yes □ No
   If yes, please state the dates and the ailments for which you attended, treated or examined. __________________________

Signature of Physician: ___________________________ Date: __________________
Print Name of Physician: ___________________________
Facility Name: ___________________________ Phone: __________________
Address: ___________________________
Please also complete the applicable section for the benefit being claimed.
To be Completed Only for Limb/Digit Amputations.

What limb/digit was severed or amputated? State the exact point at which the amputation was performed or occurred to each loss: ____________________________

Date(s) of occurrence(s): ____________________________

Cause of the amputation:
If limb or digit was reattached, what was the date and functional outcome? ____________________________

Signature of Attending: ____________________________ Date: ____________________________
Print Name of Physician: ____________________________
Facility Name: ____________________________ Phone: ____________________________
Address: ____________________________
Name of Employee: __________________________  Name of Employer: __________________________

To be Completed Only for Loss of Vision

Has the patient had entire and irrecoverable loss of sight following the injury?  
☐ Yes  ☐ No

If yes, please answer the following:
Give the date you first determined vision was is irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

Date: __________________________

Uncorrected  Corrected
O.D.v. ____________  ____________
O.S.v. ____________  ____________
(Snellen Notation)

State the cause of loss of vision:

__________________________

Indicate whether recovery or useful vision possible by operation or treatment.
O.D.  ☐ Operation  ☐ Treatment
O.S.  ☐ Operation  ☐ Treatment

If fields of vision are contracted, show on . contraction on chart below.

To be Completed Only for Burn

Has the patient suffered third degree burns as a result of an accident?  ☐ Yes  ☐ No
What percentage of the body surface suffered third degree burns? __________________________ %
Location of third degree burns: __________________________

Signature of Physician: __________________________  Date: __________________
Print Name: __________________________  Phone: __________________
Name of Facility: __________________________  Address: __________________________

HealthSCOPE Benefits • P.O. Box 2338 • Little Rock, AR 72203 • 800-323-4314
Name of Employee: ____________________________ Name of Employer:___________________________

**To be Completed for Rehabilitative Physical Therapy**

Did the patient suffer a loss resulting from an accidental injury?  □ Yes  □ No
Date of accidental injury: ____________________________
Did you prescribe rehabilitative physical therapy for the patient as a consequence of the loss?  □ Yes  □ No  Date therapy prescribed: ____________________________
Signature of Attending Physician: ____________________________ Date: ____________________________
Print Name of Attending Physician: ____________________________ Phone: ____________________________
Name of Facility: ____________________________ Address: ____________________________

**To be Completed Only for Paralysis**

Date you first determined paralysis was permanent, and irreversible, etiology of the paralysis, and method of correction and result.
   a) Date: ____________________________
   b) Etiology: ____________________________
Specific limb(s) paralyzed: ____________________________
Functional result of correction: ____________________________

Type of lesion(s) responsible: ____________________________
Test results which document paralysis (i.e., physical exam, EMG, nerve conduction tests). ____________________________
Method of correction: ____________________________

**To be Completed Only for Loss of Speech**

State duration in months of patient’s entire and irrecoverable loss of speech following the injury: ____________________________

Date you first determined speech was irrecoverably lost and the specific etiology for absence of speech (vocalization) and method and results of correction.
   a) Date: ____________________________
   b) Specify basis for speech loss: ____________________________

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<th>Desc</th>
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<th>Corrected Method</th>
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<td>Evidence of obstruction:</td>
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<td>Evidence of air passage defect:</td>
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Signature of Attending Physician: ____________________________ Date: ____________________________
Print Name: ____________________________ Phone: ____________________________
Name of Facility: ____________________________ Address: ____________________________
Name of Employee: ___________________________________________ Name of Employer: __________________________

**To be Completed Only for Loss of Hearing**

State duration in months of patient’s entire and irrecoverable loss of hearing following the injury.

Date you first determined hearing was irrecoverably lost and the residual hearing (dB) uncorrected as tested by audiometer in a soundproof room.

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Date the test results which allowed you to determine the hearing loss lasted consecutively for the duration indicated above.

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<th>a) Date: _______________</th>
<th>b) Audiometry:</th>
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**To be Completed Only for Wheelchair Access Modification**

Did the patient suffer a loss resulting from an accidental injury? □ Yes □ No
Date of accidental injury: ___________________________________________

Does the patient now require permanent use of a wheelchair for mobility? □ Yes □ No

Is the wheelchair requirement the direct and sole cause of the accidental injury? □ Yes □ No

**To be Completed Only for Brain Damage**

Has the patient suffered permanent and irreversible physical damage to the brain as a result of an accidental injury, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life? □ Yes □ No
Date of accidental injury: __________________________ Date brain damage manifested itself: __________________________

Was the patient hospitalized as a result of the accidental Injury? □ Yes □ No
Dates of hospitalization: __________________________________________

State duration, in months, brain damage persisted after the injury: __________________________

Signature of Attending Physician: __________________________________________
Print Name: __________________________________________ Date: _______________
Name of Facility: ______________________________________ Phone: _______________
Address: ________________________________________________________________
To be Completed Only For Coma

Did the patient enter into a state of deep and total unconsciousness from which he/she cannot be aroused as a result of an accidental injury? □ Yes □ No

Date of accident injury: ______________________

Date coma began: ______________________

Is the patient still in a coma? □ Yes □ No

If the patient is not in a coma now, date coma ended: ______________________

To be Completed Only for Exposure

Was the patient involved in an accident that resulted in loss of life or limb due to unavoidable exposure to the elements? □ Yes □ No

If loss of life, please explain how the exposure resulted in death: ______________________

If loss of limb, which limb(s) were lost? ______________________

State the dates on which amputations occurred: ______________________

If the limb was reattached, indicate date of reattachment and functional outcome?

State the exact point at which the performed with respect to each limb lost.

If the amputation was below the elbow or knee indicate on the chart the exact point

State the cause of the amputation:

Signature of Attending Physician: ______________________

Print Name: ______________________ Date: ______________________

Name of Facility: ______________________ Phone: ______________________

Address: ______________________