

**A. About the Insured**

Full Name		Employer/Company Name	
Group Policy No		Social Security No. _____	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone No. _____	Mailing Address _____	
City _____		State _____	ZIP _____

**B. About the Patient** – Check One  You  Spouse  Domestic Partner  Civil Union Partner  Child  
 Other \_\_\_\_\_

If the Insured is the Patient, then you do not need to complete this section again.

If this is an **Accidental Death Claim** and you are the Beneficiary, please complete this section with your information. A separate form will need to be completed and signed for each beneficiary.

Full Name		Social Security No.	Date of Birth
Relationship to Insured (if an Accidental Death Claim)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone No. _____
Mailing Address	City _____	State _____	ZIP _____

**C. About the Accident**

Date of Accident \_\_\_\_\_ Location of Accident (City, State) \_\_\_\_\_

Explain the injuries and how the accident happened (include additional information on a separate sheet of paper if needed):  
 \_\_\_\_\_  
 \_\_\_\_\_

Was the Patient in a motor vehicle accident?  Yes (Attach accident report.)  No

Was the Patient in any other type of accident that required an incident report?  Yes (Attach the incident report.)  No

Was the Patient at work when the accident occurred?  Yes (Attach a copy of the report filed with the employer.)  No

Was the Patient hospitalized?  Yes  No If Yes, complete the following:

Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_

Name of Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_

**D. Additional Benefits Claimed**

- Lodging Benefit – attach copies of receipts for lodging
- Transportation Benefit – attach copies of receipts for travel or provide mileage here if traveled by personal car \_\_\_\_\_
- Youth Organized Sport Benefit – attach proof of the Child's registration in the Organized Sport Event.
- Accidental Death Benefit – Date Death Occurred \_\_\_\_\_ . Please attach a copy of the Death Certificate.

**E. Acknowledgement**

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notices on page 3 of this Claim Packet.

Signature of Insured/Beneficiary Alice Anderson Date 1/5/2026

**C. Accidental Dismemberment and Impairment (*if applicable*)** - to be completed by Attending Physician. Please attach supporting documentation.

Did the accident result in a loss of hearing in one or both ears?  Yes  No

If Yes, then please describe \_\_\_\_\_

Did the accident result in a loss of sight in one of both eyes?  Yes  No

If Yes, then please describe \_\_\_\_\_

Did the accident result in a loss of **limb(s)**?  Yes  No

If Yes, then please describe \_\_\_\_\_

Did the accident result in **paralysis**?  Yes  No

If Yes, then please describe \_\_\_\_\_

**D. Attending Physician Information, Acknowledgement and Signature**

Name of Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**Acknowledgement**

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 8 of this form.

Physician's Signature Tom Medic Date 1/6/2026