

Standard Insurance Company

866.851.5505 Tel 402.328.4029 Fax
PO Box 85508 Lincoln NE 68501-5508

**Accident Benefits
Employee's Statement**

A. About the Insured

Full Name		Employer/Company Name	
Group Policy No	Social Security No.		Date of Birth
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

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Accident Benefits
Attending Physician's Statement

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