LifeMap | P.O. Box 1271, M/S E8L
Portland, OR 97207

Accidental Dismemberment Claim Form

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free 1 (800) 286-1129
Fax (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Claim Filing Instructions

This Statement of Accidental Dismemberment includes the forms required to apply for benefits. Please read the instructions carefully before submitting to LifeMap.

Have you…

1) Completed the **Employee's Statement**?
   a) Incomplete, unsigned, or undated statements will delay your claim
2) Signed and dated the **Authorization for Release of Information**?
3) Had the physician treating you sign and date the **Attending Physician's Statement**?
   a) The Attending Physician's Statement must be returned to you upon completion
4) Had your Employer sign and date the **Employer's Statement**?
   a) The Employer's Statement must be returned to you upon completion
5) If Policyholder is different than Employer, have you had the **Policyholder Statement** completed by the Policyholder Representative?
6) Enclosed the **Accident Report**, if available, and photocopies of **medical records** pertaining to the loss?

You are responsible for ensuring all forms are completed and returned to our office. Our review of your claim will not begin until we receive all sections completed.

Forms can be sent to LifeMap via:

Email: **claims@lifemapco.com**
Fax: **(855) 733-4615**
Regular Mail: **LifeMap Assurance Company**
Attn: Life and Disability Claims Department
PO Box 1271 MS E8L
Portland, OR 97207-1271

You are responsible for ensuring all forms are completed and returned to our office along with the required documentation. **If a form is received incomplete, unsigned or undated, it will be returned to you for completion, delaying the claim.**

If you have any questions, please call the LifeMap Life and Disability Claims Department at 1 (800) 286-1129.

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Employee's Statement

Employee Name			Social Security Number
Employee Mailing Address (Street, City, State Zip)			Home Phone Number ( )
Date of Birth	☐ Right Handed ☐ Left Handed	☐ Male ☐ Female	Cell Phone Number ( )
Employer Name		Policy Number	Employer Phone Number ( )

Dependent (Complete this section if dependent is applying for benefits)

Dependent's Name	Date of Birth	Social Security Number	Dependent's Phone Number ( )
Dependent's Mailing Address (Street, City, State Zip)			

Information about Accident and Medical Condition

Date of Accident	Location of Accident (Place, City, State)	Date of Dismemberment or Vision Loss
Did the dismemberment or vision loss arise out of, or in the course of, any employment for wage or profit? ☐ Yes ☐ No		
Describe how accident occurred. (If more space is needed, please attach sheet of paper.)		
Describe injuries and losses sustained in the accident? (If more space is needed, please attach sheet of paper.)		
Describe your current medical condition. (If more space is needed, please attach sheet of paper.)		

Attending Physician(s) (Attach a separate piece of paper if additional space is needed.)

Physician's Name	Condition(s)	Physician's Phone Number ( )
Physician's Address (Street, City, State Zip)	Period of Treatment	Physician's Fax Number ( )

Physician's Name	Condition(s)	Physician's Phone Number ( )
Physician's Address (Street, City, State Zip)	Period of Treatment	Physician's Fax Number ( )

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 3 of this form.

► _____ Employee's Signature

► _____ Date

Complete Authorization to Obtain and Release of Information form on page 4.

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Authorization to Obtain and Release Information

I authorize persons or entities having any records or knowledge of me or my health, including any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer:

To give Medical information including chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results and prognosis with respect to any physical or mental condition and/or treatment of me, excluding psychotherapy notes, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records which may have been acquired in the course of examination or treatment.

If the information to be disclosed contains any of the types or information listed below, additional laws relating to the use and disclosure may apply. I understand and agree that this information will be used or disclosed only if I place my initials in the applicable space next to the type of information:

_____ Drugs/Alcohol diagnosis, treatment or referral information
_____ Mental Health information – including provider notes
_____ HIV/AIDS information
_____ Genetic Testing Information

And Non-medical information including education, employment history, earnings or finances, vocational evaluation reports, vocational testing and rehabilitation plans, or eligibility for other benefits including retirement benefits and retirement plan contributions (for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claim status, benefit amounts, effective dates, etc.).

To LifeMap Assurance Company (LifeMap) and to its authorized representatives.

- I understand that the information obtained by use of this authorization will be used by LifeMap and authorized representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing LifeMap solely to assist with the evaluation and adjudication of my current disability claim.
- I understand that LifeMap will release information to my employer necessary for return to work and accommodation discussions, and when performing administration for my employer's self-funded (and not insured) disability plans.
- I understand that LifeMap complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to LifeMap may be subject to redisclosure and may no longer be protected under the Health Information Portability and Accountability Act (HIPAA).
- I understand that I have the right to revoke this authorization by notifying LifeMap in writing, of my revocation. However, such revocation is not effective to the extent that LifeMap has relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair the ability of LifeMap to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.
- I acknowledge that I have read this authorization. I understand and agree that this authorization shall remain in force for the duration of my claim(s) or 12 months, whichever occurs first. A photocopy or facsimile of this authorization is as valid as the original. I understand that I, or my authorized representative, have the right to request and receive a copy of this authorization and the information to which it pertains.

▶ _____ ▶ _____
Employee/Primary Insured's Full Name (please print clearly) | Social Security Number

▶ _____ ▶ _____
Employee/ Primary Insured's Signature | Date Signed

If signature is provided by legal representative (e.g. Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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Employer or Administrator's Statement

Information about Employee

Employee Name	Job Title	Social Security Number

Date Employed	Date Last Worked	Date of Termination ☐ N/A	Class

Reason for stopping work: ☐ Disability ☐ Dismissed ☐ Layoff ☐ Retired
☐ Family Medical Leave Absence ☐ Other Leave of Absence ☐ Other (Specify)

If coverage is under a union or trustee plan:
Date insured became a member: Date the insured terminated membership:

Dependent

Dependent's Name	Social Security Number

Information about Employee's Life Insurance Coverage

Effective Date	Termination Date	Last Month Premium Paid	Has Employee's Life Insurance been Converted? ☐ Yes ☐ No

Amount of Life Insurance

Member's Basic Life: $	Dependent Life: $
Member's Additional Life: $	Dependent's Additional Life: $
Member's AD&D: $	Dependent AD&D: $

Employee Earnings (Please complete this section if Life Insurance is based on earnings.)

Employee's Earnings: $	Regular scheduled hours per week:
Earnings prior to increase: $	Date of last increase:

☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ Commissions
☐ Shift Differential ☐ Bonus ☐ Other

Information about Employer

Employer Name	Location Code (If Applicable)	Policy Number

Employer Address (Street, City, State, Zip)	Phone Number ( )

Name and Title of Employer Representative Completing this Form	Email Address

Acknowledgement

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

▶ _____ ▶ _____
Employer Representative's Signature Date

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Policyholder's Statement

(Complete if Policyholder is Different than Employer)

Information about Primary Insured Member

Name of Primary Insured Member (Last, First, Middle Initial)		Social Security Number
☐ Member ☐ Spouse ☐ Domestic Partner ☐ Dependent Child	Date of Birth	Class
Name of Patient if not the Primary Insured (Last, First, Middle Initial)	Date of Birth	Social Security Number

Employee's Effective Date of Coverage with LifeMap From: To:	Employee's Premium Paid Through Date

Amount of Insurance Elected By Member:

Basic Life: $	Accidental Death: $	Dependent Life: $
Voluntary Life: $	Dependent Voluntary Life: $	Other (Specify): $

Information about Participating Employer

Participating Employer Name	Employer's Effective Dates with LifeMap From To:
Employer Address (Street, City, State, Zip)	Phone Number ( )
Employer Representative Name	Email Address

Employer's Eligibility Requirement (Hours Per Week)	Eligibility Waiting Period

Amount of Insurance Offered By Group

Basic Life: $	Accidental Death: $	Dependent Life: $
Voluntary Life: $	Dependent Voluntary Life: $	Other (Specify): $

Information about Policyholder

Policyholder Name	Policyholder Effective Date	Policy Number
Policyholder Address (Street, City, State, Zip)		Phone Number ( )
Name and title of Policyholder Representative completing this form		Email Address

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

▶ _____ ▶ _____

Signature of Policyholder Representative | Date

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Attending Physician's Statement

This statement must be filled-in completely by a physician without expense to insurance company.

Patient Information

Full name of Patient	Social Security Number
Employer Name	Group Policy Number

Information about Diagnosis

Diagnosis	ICD Code(s)

In your opinion was the loss due to an accident? ☐ Yes ☐ No

Please describe how the accident occurred including the nature of the loss. Please attach all chart notes and operative reports related to this accident.

Date of first visit for this condition	Has the patient had the same or a similar condition? ☐ Yes, if so when? ☐ No
Is condition due to the patient's employment? ☐ Yes ☐ No	Was Surgery Performed? ☐ Yes, if so when? ☐ No

Hospital Admission Date	Hospital Discharge Date	Name of Procedure(s):

Was patient treated by another provider(s) for this disability? ☐ Yes ☐ No

If Yes, please provide dates, name and address of provider(s):

Loss of Sight

Is loss of sight complete and irrecoverable? ☐ Yes ☐ No

If so, the Date loss of sight became complete and irrecoverable:

Vision at Last Observation: Corrected: Left: Right: Date: Uncorrected: Left: Right: Date:

Describe the extent of the visual field loss:

Can vision be improved by treatment, operation or lenses? ☐ Yes ☐ No

If so, please explain:

Information about the Physician

Physician's Name (Please Print)	Degree/Specialty	Phone Number ( )
Office Address (Street, City, State, Zip)		Fax Number ( )

Acknowledgement

I certify that the answers I have made to the above questions are 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.

▶ _____ ▶ _____

Attending Physician's Signature Date

Please return completed form to your patient.

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