



Accidental Dismemberment Claim Form

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.



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

LifeMap Assurance Company®

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

LifeMapCo.com

Accidental Dismemberment Claim Form

Employee's Statement

Employee Name		Social Security Number	
Employee Mailing Address (Street, City, State Zip)		Home Phone Number ()	
Date of Birth	<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed	<input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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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Insurance Fraud Warning

Unless specific state language is provided below, the following general fraud notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist, or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files, more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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Alaska, Kansas and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.



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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.



Accidental Dismemberment Claim Form

Employer or Administrator's Statement

Information about Employee

Employee Name		Job Title		Social Security Number	
Date Employed	Date Last Worked		Date of Termination	<input type="checkbox"/> N/A <input type="checkbox"/> Class	
Reason for stopping work:					
<input type="checkbox"/> Family Medical Leave Absence		<input type="checkbox"/> Disability		<input type="checkbox"/> Dismissed	
<input type="checkbox"/> Other Leave of Absence		<input type="checkbox"/> Layoff		<input type="checkbox"/> Retired	
<input type="checkbox"/> 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
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Information about Employee's Life Insurance Coverage

Effective Date	Termination Date	Last Month Premium Paid	Has Employee's Life Insurance been Converted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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:
<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Commissions	
<input type="checkbox"/> Shift Differential <input type="checkbox"/> Bonus <input type="checkbox"/> 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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Insurance Fraud Warning

LifeMapCo.com

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Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes, if so when? <input type="checkbox"/> No
Is condition due to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Surgery Performed? <input type="checkbox"/> Yes, if so when? <input type="checkbox"/> No
Hospital Admission Date	Hospital Discharge Date
Name of Procedure(s):	
Was patient treated by another provider(s) for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide dates, name and address of provider(s):	

Loss of Sight

Is loss of sight complete and irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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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