Beazley Insurance Company, Inc.
Administrative Services provided by:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: 800-508-9238
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ACCIDENTAL DEATH AND DISMEMBERMENT

Dismemberment Claim Form

INSTRUCTIONS – PLEASE READ CAREFULL'

Important instructions for completing your Accidental Dismemberment Claim.

Section 1 – Insured Information

- Section completed by the Insured. If the Insured is unable to file a claim, section should be completed by the legal representative.

Section 2 – Accident Information

- Section completed by the Insured. If the Insured is incapacitated, section should be completed by the legal representative.
- Additionally, please furnish any newspaper accounts, police or motor vehicle reports and/or other pertinent information regarding the Accident in order to facilitate consideration of the claim.

Sections 3, 3B and 3C – Physician Information

- Section for the Loss(es) for which you are filing this claim must be completed by the Attending Physician.
  Please check box(es) below to indicate the applicable Covered Loss(es)

TYPE OF LOSS	
☐ Loss of Two or More Hands or Feet	☐ Loss of One Hand or Foot
☐ Loss of Use of Two or More Hands or Feet	☐ Loss of Use of One Hand or Foot
☐ Loss of Sight of Both Eyes	☐ Severance & Reattachment of One Hand or Foot
☐ Loss of Speech and Hearing (in Both Ears)	☐ Loss of Sight in One Eye
☐ Loss of One Hand or Foot and Sight in One Eye	☐ Loss of Speech
☐ Quadriplegia	☐ Loss of Hearing (in Both Ears)
☐ Paraplegia	☐ Loss of Thumb and Index Finger on the Same Hand
☐ Hemiplegia	☐ Loss of all Four Fingers on the Same Hand
☐ Uniplegia	☐ Loss of all the Toes on the Same Foot
☐ Coma	☐ Loss of Thumb
☐ Brain Death	

- Section 3C must be signed by Physician.

Section 4 – Claimant Signature

- Section must be signed by the Member (or legal representative if member is incapacitated).

SECTION 1 INSURED INFORMATION		
Name of Insured:	Social Security Number (SSN):	Date of Birth:
Group Name:	Group Number:	Occupation:

Insurance Effective Date:	Phone: ( )	E-Mail Address:

Street Address Apt. No. City State Zip Code

SECTION 2: ACCIDENT INFORMATION

Name of Injured Person:	Date of Birth:	SSN:
Relationship to Insurer:	Occupation:	

Street Address Apt. No. City State Zip Code

Date of Accident:	Time of Accident:	Date of Loss:

Location of Accident:

Describe in detail how Accident occurred:

Describe all Injuries:

Maximum Benefit Amount for Injured: Accidental Dismemberment: $

List all investigating authorities.

Law Enforcement Agency Name:	Case #: *(Submit a copy of the accident report, if applicable.)*

Investigating Officer Name & Title:	Phone: ( )

Law Enforcement Agency Street Address City State Zip Code

Inquest Held: ☐Yes ☐No If yes, attach a copy of verdict.

List all witnesses to the accident. (Use additional sheet if necessary.)

Witness Name:	Phone: ( )

Street Address Apt. No. City State Zip Code

Witness Name:	Phone: ( )

Street Address Apt. No. City State Zip Code

Witness Name:	Phone: ( )

Street Address Apt. No. City State Zip Code

List all physicians and surgeons who attended the Insured for Injuries incurred in the Accident (Use additional sheet if necessary.)

Physician Consulted:	Phone: ( )

Street Address City State Zip Code

Physician Consulted:	Phone: ( )

Street Address City State Zip Code

Physician Consulted:	Phone: ( )

Street Address City State Zip Code

Hospital Consulted for this injury:	Phone: ( )

Street Address City State Zip Code

SECTION 3: ATTENDING PHYSICIAN INFORMATION

Patient Name:	Date of Accident:	Date First Consulted:
Date symptoms first occurred:	Diagnosis or Nature of Injury:	
Did the Patient ever have the same or similar symptoms previously: ☐Yes ☐No	If yes, Date Consulted:	
Describe the Accident:		

SECTION 3B: PHYSICIAN DESCRIPTION OF COVERED LOSS(ES) *[Please complete appropriated sections(s)]*

Loss of a Hand or Foot

If loss is extremity, location of severance: ☐Left wrist ☐ Right wrist ☐ Left Foot ☐ Right Foot
Did severance occur above or through the limb? ☐Yes ☐No

If severance was a hand or foot, was limb reattached: ☐Yes ☐No	If yes, date of surgery:

Loss of Use of Hand or Foot

Which extremity is affected: ☐Left wrist ☐ Right wrist ☐ Left Foot ☐ Right Foot

Has the patient lost total use of the hand or foot? ☐Yes ☐No	If yes, Date of Loss:
Is the condition expected to last the remainder of the patient's life: ☐Yes ☐No	If no, please explain:

Loss of a Thumb and/or Fingers

Loss of a Thumb and Index Finger of the Same Hand: ☐Left Hand ☐Right Hand
Loss of Four Fingers on the Same Hand: ☐Left Hand ☐Right Hand
Loss of Thumb Only: ☐Left Hand ☐Right Hand
Were the metacarpophalangeal joints completely severed? ☐Yes ☐No

Loss of All Toes on the Same Foot

☐ Left Foot ☐ Right Foot
Were the metatarsophalangeal joints completed severed? ☐Yes ☐No

Loss of Sight

Date of First Eye Examination:	Date of Accident:	Date of Loss:
If loss of sight, indicate which eye: ☐Left ☐Right ☐Both	Is loss total and irrecoverable by natural, surgical or artificial means: ☐Yes ☐No	
Did the Injury necessitate the remove of either or both eyes? ☐Yes ☐No	If yes, which eye: ☐Left ☐Right ☐Both	If yes, Date of Removal:

Are you aware of a disease or condition prior to the accident, which may have served as a contributory cause: ☐Yes ☐No *If yes, supply medical records.*	Visual Acuity (Using Snellen Notation or its equivalent)	
	Uncorrected	Corrected
In your opinion, can vision be improved by treatment, operation or lenses: ☐Yes ☐No	O.D.:	O.D.:
	O.S.	O.S.:

State your recommendations:

Loss of Speech

Has the patient suffered total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means: ☐Yes ☐No

Loss of Hearing

Has the patient suffered total and permanent loss of ability to hear any sound **in both ears** which is irrecoverable by natural, surgical or artificial means: ☐Yes ☐No

Paralysis

Please check the section that applies to your patient:

- ☐ **Quadriplegia** means the complete and irreversible Paralysis of both upper and lower limbs
- ☐ **Paraplegia** means the complete and irreversible Paralysis of both lower limbs or both upper limbs
- ☐ **Hemiplegia** means the complete of irreversible Paralysis of the upper and lower limbs on both sides of the body
- ☐ **Uniplegia** means the complete and irreversible Paralysis of one limb.

(section continued on next page)

Date Patient Became Paralyzed:

Was Paralysis a direct result of the accident or injury: ☐Yes ☐No	
If no, explain:	
Coma	
Onset Date of Coma:	Was the Coma a direct result of the accident or injury: ☐Yes ☐No
If no, explain:	
Was the Patient treated regularly? ☐Yes ☐No	If yes, where was the Patient being treated?
Brain Death	
Is the Patient in an irreversible state of unconsciousness, resulting directly from the accident or injury: ☐Yes ☐No	
Has the Patient suffered total loss of brain function and complete absence of electrical activity of the brain: ☐Yes ☐No	
Onset or Diagnosis Date:	

3C: ATTENDING PHYSICIAN SIGNATURE *(This form must be signed.)*

Attending Physician Name:			Phone: ( )
Street Address	City	State	Zip Code
Signature:		Date:	

SECTION 4: CLAIMANT SIGNATURE *(This form must be signed.)*

AUTHORIZATION AND ACKNOWLEDGMENT

I hereby certify that the above information is true and correct to the best of my knowledge.
(Please continue to read below for special notices required by state law.)

X _____ _____

Signature of Person Completing Form | Date Signed

SECTION 5: EMPLOYER STATEMENT *(to be completed in full along with copy of enrollment form)*

Name of Insured Employee:	Social Security Number:	Date of Birth:
Name of Deceased or Injured:	Social Security Number:	Date of Birth:
Relationship to Employee:	Employee Class:	Phone: ( )
Date Last Physically Reported for Work:	Employee Insurance in-force: ☐Yes ☐No	Effective Date:
	Dependent Insurance in-force: ☐Yes ☐No	Effective Date:

Date of Injury:	Date of Death, if applicable:
Death or injury occurred when the employee was working: ☐Yes ☐No	If yes, please describe circumstances:
Amount of Employee's Insurance Coverage	**Amount of Dependent Insurance in-force**
Accidental Death: $	Accidental Death: $
Accidental Dismemberment: $	Accidental Dismemberment: $

EMPLOYER SIGNATURE *(This form must be signed by Employer Group's authorized representative.)*

Employer Name:	Group Number:	Effective Date of Group Policy:
Name of Authorized Person:		Title:
Street Address	City State Zip Code	

If Branch or Affiliate, Name of Parent Company:		Employer Social Security or Tax ID Number:
Phone Number: ( )	Fax Number: ( )	E-Mail Address:

I hereby certify that the above information is true and correct to the best of my knowledge.

Please continue to read below for special notices required by state law.

X _____ _____

Authorized [Employer] Signature Date Signed

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia - 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 fines and confinement in prison.

California - 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.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware - 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.

District of Columbia - 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.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas – It is unlawful to commit a fraudulent insurance act, which means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia, Washington - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company.

Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire - Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

New Mexico – Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Ohio - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Oregon - Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania - 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.

Vermont - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.