HealthChoice

Overview of Accidental Dismemberment Claim Form for EMPLOYEE

To the Employer and Employee/Beneficiary:

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Please take note of the Fraud Notice that follows.

Fraud Notice: 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 fine and confinement in prison.

The information below constitutes a complete claim filed with HealthChoice for purposes of claiming dismemberment benefits.

PART I – Employer's Statement

- Form is to be completed in its entirety and signed by the official representative of the employer/plan.
- Proof of salary as defined in the policy (attach commission, if applicable).
- Submission of claims on any voluntary or contributory life plan, and copies of the enrollment forms and history to show timely enrollment.

PART II – Claimant's Statement

- Must be completed by claimant or insured claiming any dismemberment due to an accident.
- Additionally, please furnish any police or motor vehicle reports, toxicology or other pertinent information regarding the claim for accidental dismemberment or injury.
- Your signature on the Authorization for Release of Information.

Part III – Attending Physician's Statement

- For dismemberment
- For loss of sight
- For loss of hearing
- For loss of speech

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization.

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Dismemberment Claim Form

To avoid a delay or denial of benefits, please complete all applicable questions and submit medical records, supporting accident reports and toxicology reports documenting the accidental injury.

EMPLOYEE STATEMENT (To be completed by employee or member)

Employee Name: _____

Address: _____

City: _____ State: _____ ZIP: _____ Email Address: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

SSN: _____ Occupation: _____

Benefit Claimed: □ Loss of hand □ Loss of foot □ Loss of eye □ Quadriplegic □ Paraplegic

□ Hemiplegic □ Loss of two or more members □ Other _____

Total Group Accidental Life: Basic AD&D _____ Opt AD&D _____ Vol AD&D _____

Benefit amount: Basic AD&D _____ Opt AD&D _____ Vol AD&D _____

INJURY STATEMENT

Name of Person Injured: _____

Date of Birth: _____ Age: _____

Social Security Number: _____ Occupation: _____

Date of Accident: _____ Did the accident happen on the job? □ Yes □ No

Did this accident occur during the participation of a hobby that may be deemed hazardous?

□ Yes □ No

Briefly Describe the Accident: _____

Physician Name: _____ Specialty: _____

Physician Address: _____

Hospital Name: _____

Hospital Address: _____

Hospital Phone: _____ Hospital Fax: _____

These statements are true and complete to the best of my knowledge. I have completed and attached the Authorization for Release of Information. A photostatic copy of this form will be as valid as the original.

Signature of Employee: _____ Date: _____

Please also complete Authorization for Release of Information contained in this packet.

Payment Method □ Direct Deposit Financial Institution's Name: _____

Type of Account □ Checking Bank/Routing Number: _____

Checking Account Number: _____

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Dismemberment Claim

EMPLOYER'S STATEMENT (To be completed by the employer)

Group Name: _____

Group Plan Number: _____

Phone: _____ Fax: _____ Email: _____

Employee Hire Date: _____ Effective Plan Coverage Date: _____

Employee Status: _____ Plan ID: _____

Did the Employee Elect?

Basic Life Coverage Plan: □ Yes □ No

Supplemental Life Coverage: □ Yes □ No

Amount of Benefit: AD&D under Basic Life Coverage $ _____

Was the employee still employed on date of accident? □ Yes □ No

Amount of Benefit: AD&D under Basic Supplemental Life Coverage $ _____

Was the employee still employed on date of accident? □ Yes □ No

Print Name: _____ Title: _____

Signature: _____ Date: _____

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Authorization For Release of Information

I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility, insurance, government agency, department of labor, law enforcement or public safety department, group policyholder; employer; or policy or benefit plan administrator to release information from the records of Claimant/Insured:

First :_____ MI:_____ Last:_____

Date of Birth:_____ Social Security Number:_____

1. Claimant Information to be released:
   - Data or records regarding medical history, treatment, prescriptions, consultations, (including medical and psychological reports, records, charts, notes [excluding psychotherapy notes], X-rays films or correspondence, and any medical condition(s)).
   - Any information regarding insurance coverage.
   - Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
2. Information to be released to: HealthSCOPE Benefits
   P.O. Box 2338
   Little Rock, AR 72203.
   HealthSCOPE Benefits is the administrator of HealthChoice Life Insurance Plan.
3. I understand the information obtained by use of the authorization will be used by HealthSCOPE Benefits (Company) to evaluate my claim for dismemberment/plegia benefits. The Company will only release such information:
   - To other persons or organizations performing business or legal services in connection with my claims(s);
   - As otherwise may be required by law or as I may further authorize.

   I further understand that refusal to sign this authorization may result in the denial of benefits.
4. I understand that I may revoke this authorization in writing at any time, except to the extent:
   1. The Company has taken action in reliance on this authorization.
   2. The Company is using this authorization in connection with a contestable claim.

   If written revocation is not received, this authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this authorization, direct all correspondence to the Company at the above address.
5. A photocopy of this authorization is to be considered as valid as the original.
6. I understand I am entitled to receive a copy of this authorization.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____PHONE: _____

Relationship to claimant for personal/legal representative signing for claimant.
Power of attorney or guardianship must be attached.

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Name of Employee:_____ Employer's Name: _____

Attending Physician's Statement

1. Name of patient: (First, MI Last)_____ Age: _____
2. Date of accident causing present loss: (Month, Day, Year)_____
3. Date first consulted on account of the injury described:
4. Date of last treatment fie this condition: (Month, Day, Year)_____
5. Describe the exact nature, location and extent of all injuries sustained:_____

   _____

   _____

6. Was the injury described solely responsible for the loss? □ Yes □ No

   If not, give the particular of any contributing cause or causes. _____

   _____

7. Names of any other physicians who treated the patient for a contributory condition and the dates of their first and last treatments as reported to you _____

   _____

8. In your opinion, was the loss caused in any way by illness? □ Yes □ No

   If yes, what was the date you provided treatment for the illness? _____

9. Did the patient ever consult you before? □ Yes □ No

   If yes, please state the dates and the ailments for which you attended, treated or examined.

   _____

   _____

Signature of Physician: _____ Date: _____

Print Name of Physician: _____

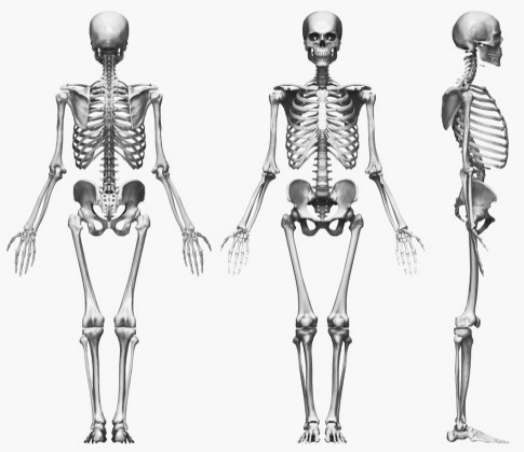
Facility Name: _____ Phone: _____

Address: _____

Please also complete the applicable section for the benefit being claimed.

To be Completed Only for Limb/Digit Amputations.

What limb/digit was severed or amputated? State the exact point at which the amputation was performed or occurred to each loss: _____



Date(s) of occurrence(s): _____

Cause of the amputation:

If limb or digit was reattached, what was the date and functional outcome? _____

_____

Signature of Attending: _____ Date: _____

Print Name of Physician: _____

Facility Name: _____ Phone: _____

Address: _____

Name of Employee: _____ Name of Employer: _____

To be Completed Only for Loss of Vision

Has the patient had entire and irrecoverable loss of sight following the injury?
□ Yes □ No
If yes, please answer the following:
Give the date you first determined vision was is irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

Date: _____

State the cause of loss of vision:
_____
_____
_____

Indicate whether recovery or useful vision possible by operation or treatment.
O.D. □ Operation □ Treatment
O.S. □ Operation □ Treatment

	Uncorrected	Corrected
O.D.v.	_____	_____
O.S.v.	_____	_____

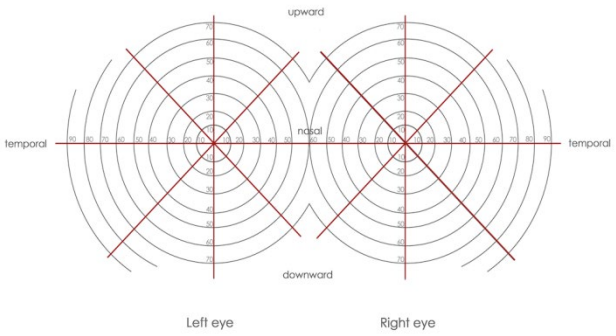
(Snellen Notation)

Give the date and vision found on last eye examination. Date: _____

	Uncorrected	Corrected
O.D.v.	_____	_____
O.S.v.	_____	_____

(Snellen Notation)

If fields of vision are contracted, show on . contraction on chart below.



To be Completed Only for Burn

Has the patient suffered third degree burns as a result of an accident? □ Yes □ No
What percentage of the body surface suffered third degree burns? _____ %
Location of third degree burns: _____

Signature of Physician: _____
Print Name: _____ Date: _____
Name of Facility: _____ Phone: _____
Address: _____

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Name of Employee: _____ Name of Employer: _____

To be Completed for Rehabilitative Physical Therapy

Did the patient suffer a loss resulting from an accidental injury? □ Yes □ No

Date of accidental injury: _____

Did you prescribe rehabilitative physical therapy for the patient as a consequence of the loss?

□ Yes □ No Date therapy prescribed: _____

Signature of Attending Physician: _____ Date: _____

Print Name of Attending Physician: _____

Name of Facility: _____ Phone: _____

Address: _____

To be Completed Only for Paralysis

Date you first determined paralysis was permanent, and irreversible, etiology of the paralysis, and method of correction and result.

a) Date: _____

b) Etiology: _____

Specific limb(s) paralyzed: _____

_____

Functional result of correction: _____

_____

Type of lesion(s) responsible: _____

_____

_____

Test results which document paralysis (i.e., physical exam, EMG, nerve conduction tests). _____

Method of correction: _____

_____

_____

To be Completed Only for Loss of Speech

State duration in months of patient's entire and irrecoverable loss of speech following the injury:

_____

Date you first determined speech was irrecoverably lost and the specific etiology for absence of speech (vocalization) and method and results of correction.

a). Date: _____

b). Specify basis for speech loss: Desc Uncorrected Corrected Method

Absence of vocalization structure(s): _____

Evidence of obstruction: _____

Evidence of air passage defect: _____

Signature of Attending Physician: _____

Print Name: _____ Date: _____

Name of Facility: _____ Phone: _____

Address: _____

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Name of Employee: _____ Name of Employer: _____

To be Completed Only for Loss of Hearing

State duration in months of patient's entire and irrecoverable loss of hearing following the injury.

_____

Date you first determined hearing was irrecoverably lost and the residual hearing (dB) uncorrected as tested by audiometer in a soundproof room.

a) Date: _____

b) Audiometry: Left Right

	Uncorrected/ Corrected	Uncorrected/ Corrected
500 HZ	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

Date the test results which allowed you to determine the hearing loss lasted consecutively for the duration indicated above.

a) Date: _____

b) Audiometry: Left Right

	Uncorrected/ Corrected	Uncorrected/Corrected
500 Hz	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

To be Completed Only for Wheelchair Access Modification

Did the patient suffer a loss resulting from an accidental injury? □ Yes □ No

Date of accidental injury: _____

Does the patient now require permanent use of a wheelchair for mobility? □ Yes □ No

Is the wheelchair requirement the direct and sole cause of the accidental injury? □ Yes □ No

To be Completed Only for Brain Damage

Has the patient suffered permanent and irreversible physical damage to the brain as a result of an accidental injury, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life? □ Yes □ No

Date of accidental injury: _____ Date brain damage manifested itself: _____

Was the patient hospitalized as a result of the accidental Injury? □ Yes □ No

Dates of hospitalization: _____

State duration, in months, brain damage persisted after the injury: _____

Signature of Attending Physician: _____

Print Name: _____ Date: _____

Name of Facility: _____ Phone: _____

Address: _____

Name of Employee: _____ Name of Employer: _____

To be Completed Only For Coma

Did the patient enter into a state of deep and total unconsciousness from which he/she cannot be aroused as a result of an accidental injury? □ Yes □ No

Date of accident injury: _____

Date coma began: _____

Is the patient still in a coma? □ Yes □ No

If the patient is not in a coma now, date coma ended: _____

To be Completed Only for Exposure

Was the patient involved in an accident that resulted in loss of life or limb due to unavoidable exposure to the elements? □ Yes □ No

If loss of life, please explain how the exposure resulted in death: _____

_____

_____

If loss of limb, which limb(s) were lost? _____

_____

State the dates on which amputations occurred:

_____

If the limb was reattached, indicate date of reattachment and functional outcome?

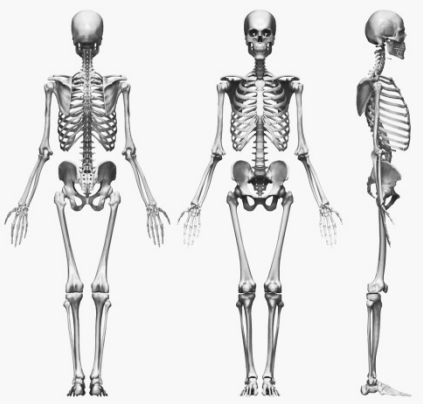
_____

State the exact point at which the performed with respect to each limb lost. If the amputation was below the elbow or knee indicate on the chart the exact point

State the cause of the amputation:

_____

_____



Signature of Attending Physician: _____

Print Name: _____ Date: _____

Name of Facility: _____ Phone: _____

Address: _____