USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone (800) 370-5856 Fax (501)235-8416
E-mail: claims@usablelife.com

Statement of Claim
Group Accident Insurance

Please type or print in blue or black ink.

For H.O. Use Only
Eff _____
PTD _____
Benefits _____

Important: Read Carefully

This form should be completed by the attending physician and by the claimant upon the death or loss by an insured employee or dependent and should be forwarded to USAble Life. It will be necessary to furnish a copy of the investigating officer's report for loss due to suicide, homicide or motor vehicle accident. An official Certified Death Certificate is also required for loss of life claims. By furnishing this form and investigating this claim, USAble Life shall not be held to admit the validity of any claim or to waive or breach any condition of the policy.

CLAIMANT'S STATEMENT

Name of Insured	Social Security #	Age	Sex ☐ Male ☐ Female
Home Address (Number and Street) (City, State) (Zip)			Daytime Telephone Number
Name of Person Suffering Loss of Life, Limb or Sight	Date of Birth	Sex ☐ Male ☐ Female	Relation to Insured
Home Address (Number and Street) (City, State) (Zip)			
Loss Suffered ☐ Loss of Life (attach Certificate of Death) ☐ Loss of Limb ☐ Loss of Sight ☐ Loss of Thumb & Index Finger			
Name of Claimant	Date of Birth	Relation to Insured	Claimant Is: ☐ Beneficiary ☐ Insured ☐ Other
Home Address (Number and Street) (City, State) (Zip)			Daytime Telephone Number
Where Injury Happened (Street, City, State)	When Injury Happened (Date and Time)		Date of Death (if applicable)
How Injury Happened			
Other Accidental Death or Dismemberment Ins. ☐ Yes ☐ No	Name of Insurance Company Address (City, State)	Policy No.	Amount of Insurance

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original.

FRAUD WARNING: Except as noted in separate Fraud notice, it is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date: _____ **Signature of Claimant** _____
(Parent/Guardian if Minor)

EMPLOYER'S STATEMENT

Full Name of Insured	Age	Sex ☐ Male ☐ Female	Marital Status	Certificate No.	Policy No.
Name of Person Suffering Loss of Life, Limb or Sight	Occupation	Age	Sex ☐ Male ☐ Female	Marital Status	
Date Insurance Became Effective on Such Person	Amount of Insurance in Force on Such Person	Was Loss Due to an Occupational Accident?	Date of Death or Dismemberment	Was Insurance in Effect on Date of Accident? ☐ Yes ☐ No	
Name of Beneficiary (if death claim)	Social Security #	Date of Birth	Relationship to Deceased		
Is Beneficiary a Minor? If So, Give Full Name and Address of Guardian. (Certified copy of court order appointing guardian must be attached.)					

The following line is to be completed ONLY if the employee is the person suffering loss.

Date Hired	Date Employee last worked	Reason for Stopping Work ☐ Illness ☐ Layoff ☐ Leave of Absence ☐ Retired ☐ Other (explain)	Date Employment Terminated	Was Employee ☐ Full-time ☐ Part-Time ☐ Hourly ☐ Salaried
Name of Policyholder/Employer		Address		Telephone
Name of Authorized Representative (Please Print)		Signature		Date Signed

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ATTENDING PHYSICIAN'S STATEMENT

Section I - Please complete this section if claim is for loss of life. If loss of sight/dismemberment, complete Section II below.

Name of Deceased			Age at Death
Residence at Time of Death (Number and Street)	(City, State)		(Zip)
Date of Death	Place (if in hospital or institution, give name)		
Immediate Cause of Death (Include ICD Codes)			
Was Death Due To ☐ Suicide ☐ Homicide ☐ Illness ☐ Accidental Bodily Injury			
If Injury, Give Details and Date			
Were there any contributing causes of death? Give the dates and duration of each as closely as you can.			
Was there an autopsy, inquest, or post mortem examination? By whom?			

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician's Signature			**Date**
Physician's Name			**Degree**
Address			**Telephone**
City	**State**	**Zip**	**Fax**

Section II - This portion is to be completed if the claim is for loss of sight or dismemberment.

Name of Patient			Date of Birth
Home Address (Number and Street)	(City, State)		(Zip)
Nature of Injury (Include ICD Codes)			When Did It Occur?
If loss of limb, was it through or above wrist or ankle joint? ☐ Yes ☐ No	If loss of thumb and index finger, is it above the metacarpophalangeal joint? ☐ Yes ☐ No	If loss of sight, is it entire and irrecoverable? ☐ Yes ☐ No	If yes, on what date did it become so?
Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? ☐ Yes ☐ No If No, please explain:			
Were any surgical procedures involved? ☐ Yes ☐ No Please Describe:			Date Performed

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician's Signature			**Date**
Physician's Name			**Degree**
Address			**Telephone**
City	**State**	**Zip**	**Fax**

⚠ USABLE® LIFE | **FRAUD NOTICE**

FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING 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 fines and confinement in prison. Please see below for special notices required by state law.

AL Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK Residents Only: Any 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.

AZ Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: Any person who knowingly presents a 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.

CO Residents Only: 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.

DE, ID, IN, OK Residents Only: 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.

DC Residents Only: 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.

FL Residents Only: 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 of the third degree.

KS Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison as determined by a court of law.

KY Residents Only: 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.

ME and TN Residents Only: 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 and denial of insurance benefits.

MD, RI, TX Residents Only: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH Residents Only: 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.

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

OH Residents Only: Any person who, with the 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.

OR Residents Only: 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 may be guilty of a crime and subject to fines and confinement in prison.

PA Residents Only: 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.

VT Resident Only: 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.

VA and WA Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

▼ SIGN AND DATE BELOW

I have read and understand the Fraud Warning that applies to my state of residence.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE