

CHARTIS  
A&H Claims Department  
P. O. Box 25987  
Shawnee Mission, KS 66225  
800-551-0824 fax: 866.831.3636

**PROOF OF LOSS - ACCIDENTAL DISMEMBERMENT/PARALYSIS**

**National Union Fire Insurance Co. of  
Pittsburgh**

**NAME OF GROUP:**  
**POLICY NUMBER:**

**POLICYHOLDER INSTRUCTIONS**

In order to assure prompt processing of this claim, please forward the claim form to the Policyholder and Claimant. The Policyholder must complete PART A in its entirety. Due to recent changes in tax laws, the Claimant will be required to complete PART B. Be certain that PARTS C and D on the reverse side are completed in full and signed by the Claimant and Attending Physician, respectively. The Claimant is responsible having the Attending Physician's complete Part D without expense to the Company.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary.

**If you have questions completing this form, call the Policyholder at (insert phone number here)**

**Please return this form and other documentation to the Policyholder:  
(policyholder needs to insert information here depending on if they want the claim form to be returned to them or sent to us directly)**

**PART A: POLICYHOLDER INFORMATION**

POLICYHOLDER			
POLICYHOLDER ADDRESS		NAME/TITLE OF REPRESENTATIVE COMPLETING FORM	
MEMBER NAME AND ADDRESS		DATE OF ACCIDENT	
EFFECTIVE DATE OF COVERAGE	MEMBER SOCIAL SECURITY NUMBER	DATE OF BIRTH	MEMBER OCCUPATION
CLASSIFICATION OR PROGRAM NAME	COVERAGE AMOUNT	<input type="checkbox"/> INDIVIDUAL MEMBERSHIP <input type="checkbox"/> FAMILY MEMBERSHIP	IF FAMILY, OTHER MEMBER NAMES
STATUS OF MEMBER ON LOSS DATE			
<input type="checkbox"/> ACTIVE	<input type="checkbox"/> RETIRED	<input type="checkbox"/> PREMIUM WAIVER FOR DISABILITY	<input type="checkbox"/> OTHER

**If Claim is For Dependent, Provide the Following:**

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT
DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER	

**POLICYHOLDER SIGNATURE**

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER AND EMAIL ADDRESS
NAME/TITLE OF AUTHORIZED REPRESENTATIVE		BY (THEIR AUTHORIZED REPRESENTATIVE)
		<b>X</b>

**PART B: IMPORTANT TAX INFORMATION**

**To Be Completed by Claimant**

Social Security Number/  
Tax ID Number

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**Please Print or Type Name of Claimant**

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

**Be Certain Part C on the Reverse Side is Completed**

**PART C: CLAIMANT INFORMATION**

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY) DESCRIBE INJURIES RECEIVED.

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED EMPLOYEE/MEMBER FOR THESE INJURIES

NAME	ADDRESS	PHONE NUMBER
NAME	ADDRESS	PHONE NUMBER

LIST ALL WITNESSES TO ACCIDENT

NAME	ADDRESS	PHONE NUMBER
NAME	ADDRESS	PHONE NUMBER

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF**

**AUTHORIZATION**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

**California:** For your protection, California law requires the following to appear on this form: 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.

**For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.

**For residents of Pennsylvania:** 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 and subjects such person to criminal and civil penalties.

**For claimants not residing in California, New York, or Pennsylvania:** 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.

SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS OF CLAIMANT, OR AUTHORIZED REPRESENTATIVE(No., STREET, CITY, STATE)	BUSINESS PHONE NUMBER ( )	HOME PHONE NUMBER ( )

**PART D: ATTENDING PHYSICIAN'S STATEMENT**

**THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION OF THIS STATEMENT WITHOUT EXPENSE TO THE COMPANY.**

NAME OF PATIENT	AGE	ADDRESS (STREET, CITY, STATE, ZIP CODE)
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NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID ACCIDENT HAPPEN? (MO., DAY, YEAR)	WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MO., DAY, YEAR)
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DID THE ACCIDENTAL INJURY RESULT IN:

LOSS OF HANDS?	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	WAS SEVERANCE AT OR ABOVE WRIST JOINT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF SEVERANCE	EXTENT OF SEVERANCE	
LOSS OF THUMB AND INDEX FINGER OF SAME HAND?	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	WAS SEVERANCE THROUGH OR ABOVE METACARPOPHALANGEAL JOINT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF SEVERANCE	EXTENT OF SEVERANCE	
LOSS OF FEET?	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	WAS SEVERANCE AT OR ABOVE ANKLE JOINT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF SEVERANCE	EXTENT OF SEVERANCE	
TOTAL AND IRRECOVERABLE	RIGHT EYE	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF LOSS	WAS EYE REMOVED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REMOVED
LOSS OF SIGHT OF:	LEFT EYE	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF LOSS	WAS EYE REMOVED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REMOVED
TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF LOSS			

PARALYSIS     QUADRIPLÉGIA     PARAPLEGIA     HEMIPLEGIA

IN YOUR OPINION, WAS ANY DISEASE, INFECTION, BODILY OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?

IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION?     YES     NO

IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGHT, PLEASE ANSWER THE FOLLOWING QUESTIONS:

IF THE LOSS OF SIGHT IS PARTIAL, BUT IRRECOVERABLE, PLEASE STATE AMOUNT OF VISION IN EACH EYE WITH SNELLEN NOTATIONS, OR JAEGER SCALE, IF PERTINENT.

UNCORRECTED	CORRECTED	DATE OF EXAMINATION
O.D.	O.S.	O.D.    O.S.

DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR OPERATION?     YES     NO

IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE.

WAS PATIENT CONFINED TO A HOSPITAL?     YES     NO    IF "YES," GIVE NAME AND ADDRESS OF HOSPITAL.

**TREATMENT**

DATE OF FIRST VISIT	DATES OF SUBSEQUENT VISITS			
SIGNATURE OF ATTENDING PHYSICIAN	PHYSICIAN'S NAME (PLEASE PRINT)	DEGREE	TELEPHONE ( )	DATE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?     YES     NO

IF DISCHARGED, GIVE DATE OF DISCHARGE:

