UnitedHealthcare Insurance Company

STATEMENT OF CLAIM

FOR ACCIDENTAL DISMEMBERMENT BENEFITS

UnitedHealthcare Specialty Benefits
PO Box 7149
Portland ME 04112-7149
1-866-293-1794
Fax: 1-800-980-0298

UnitedHealthcare®

For persons who live in 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.

For persons who live in Maryland: 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.

For persons who live in all other states: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

TO BE COMPLETED BY THE EMPLOYEE

(Please answer all questions)

1. Employee's name (print) _____ Age _____
   Employee Social Security #
2. Employee phone number with area code _____
3. Present Address _____
   (Number) (Street) (City) (State) (Zip Code)
4. When did the accident happen? Date _____ YR _____ at _____ a.m.
   (hour) p.m.
5. Where did the accident happen? City _____ State _____
6. Give a brief description of the accident _____

_____

7. Please attach (a) copy of your accident report and any newsletter clippings giving details of the accident.
   (b) copy of the toxicology report if you were the driver in a motor vehicle accident.

I authorize the physician to release any information requested with respect to this Claim.
I certify that the information I furnished to support this claim is true and correct. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

Date _____ YR _____ Signed _____
(Insured employee)

TO BE COMPLETED BY THE EMPLOYER

(PLEASE ANSWER ALL QUESTIONS)

1. Employee's name _____ Certificate No. _____ Group No. _____
2. Amount of Accidental Dismemberment Benefit, (Full) $_____ Half $_____ Issued Date _____ YR ___
3. If this coverage has been canceled, give the date and reason _____
4. (a) Date last worked _____ YR _____
   (b) Date returned to work _____ YR _____
5. Has this claim been considered in connection with worker's compensation coverage? ☐ Yes ☐ NO

If "Yes", what is the present status of the compensation claim ? _____

6. Give any information which might assist the Company in consideration of this claim.
7. Please attach (a) copy of the employee's insurance record cards.

Date _____ YR _____

Employer _____
(Name and Address) (Phone - Area Code and No.)

Signed by _____

Title _____

IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE OUT FACTS YOU KNOW ARE IMPORTANT.
TO BE COMPLETED BY THE ATTENDING PHYSICIAN

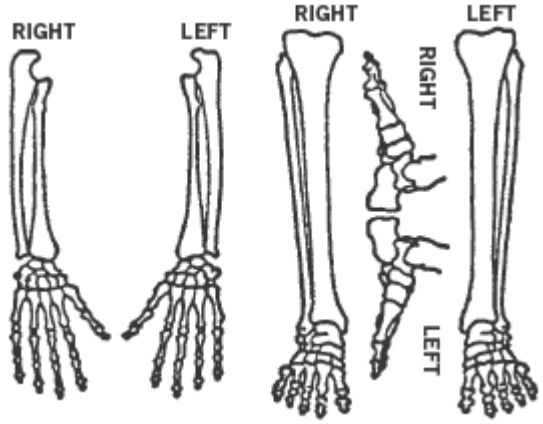
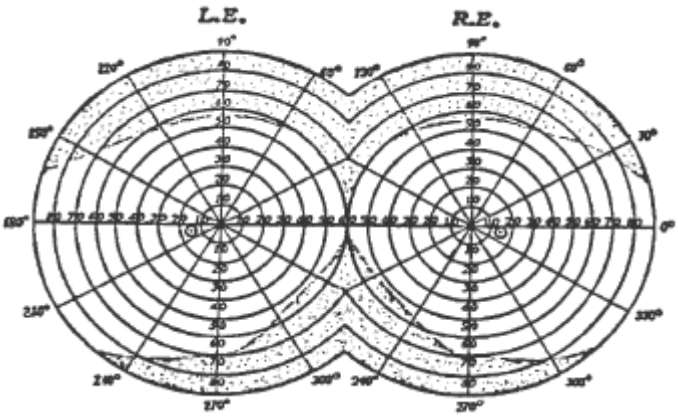
1. Name of patient _____ Age _____

2. (a) Date first consulted on account of the injury described _____ YR _____

(b) Date of last treatment _____ YR _____

3. Describe the exact nature, location, and extend of all injuries sustained _____

_____

TO BE COMPLETED ONLY FOR AMPUTATIONS	**TO BE COMPLETED ONLY FOR LOSS OF VISION**
4. (a) which limbs were severed or amputated?	4. Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notations) or less with correction and the vision then remaining in each eye.
(b) State the dates on which the severances or amputations occurred.	(a) Date_____ (b) (Snellen Noations) O.D.v. / Uncorrected / Corrected / O.S.v. / / /
(c) State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint indicate on the chart the exact point of severance	5. Give the date and vision found on last eye examination. (a) Date_____ (b) (Snellen Noations) O.D.v. / Uncorrected / Corrected / O.S.v. / / /
5. State the cause of the amputations.	
6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated, or examined.	6. State the cause of loss of vision.
7. Please give the names of such other physicians as have attended this patient, and the dates of their first and last treatments as reported to you	7. Indicate whether recover or useful vision is possible by operation or Treatment. O.D. ☐ Operation ☐ Treatment O.S. ☐ Operation ☐ Treatment
	7a If fields of vision are contracted, show contraction on chart below. 

8. (a) Was the injury described solely responsible for the loss? _____

(b) If not, give the particulars of any contributing cause or causes _____

_____

_____

Signed _____
(Attending Physician)

Address _____

_____

Date _____ YR _____ Phone No _____