

Notice of Accidental Dismemberment and Loss of Sight Claim State of Georgia

Minnesota Life Insurance Company • Group Division Claims • Atlanta Branch Office
260 Peachtree Street NW, Suite 1203 • Atlanta, Georgia 30303

For Claim Information Call:
Toll Free 1 800-660-2519
Fax 404-522-1655

MINNESOTA LIFE

TO BE COMPLETED BY EMPLOYER

EMPLOYER'S NAME		POLICY NUMBER	
EMPLOYEE DATE OF BIRTH (MONTH, DAY, YEAR)	DATE EMPLOYED (MONTH, DAY, YEAR)	SALARY \$	PER <input type="checkbox"/> HOUR <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH
JOB TITLE	DATE LAST ACTIVELY WORKED		
STATUS ON LAST DAY WORKED <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME If part-time, average hours per week. _____			
Amount of Employee's Coverage		Effective Date of Coverage	
Coverage Amount \$ _____		_____	
(1, 2, 3, 4, 5, 6, or 7x)			

EMPLOYER CERTIFICATION: The undersigned certifies that above statements as to the employee are correct as reported on its records.

NAME OF EMPLOYER	EMPLOYER'S TELEPHONE NUMBER
EMPLOYER'S ADDRESS	
AUTHORIZED SIGNATURE X	DATE

CLAIMANT'S STATEMENT

To present your claim for benefits, complete this Claimant's Statement. All questions must be fully completed. Have your physician complete the Attending Physician's Statement and attach copies of your medical records. Please be sure to sign and date the authorization.

CLAIMANT'S LEGAL NAME (Last, First, Middle' Initial)	DATE OF BIRTH (Mo/Day/Yr)	SOCIAL SECURITY NUMBER
ADDRESS (Street, City, State, Zip)	TELEPHONE NUMBER ()	
DATE ACCIDENT OCCURRED	WHERE ACCIDENT OCCURRED	

Did the accident result in dismemberment or total and irrecoverable loss of sight? Yes No

Please fully describe the accident.

If the dismemberment, total and irrevocable loss of sight occurred on a date later than the date of the accident, please list that date.

NAME AND ADDRESS OF PHYSICIAN TREATING YOU	TELEPHONE NUMBER ()
NAME AND ADDRESS OF HOSPITAL	TELEPHONE NUMBER ()

For the purpose of determining my eligibility for insurance coverage and benefits, I authorize any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge, including but not limited to my physical or mental health or financial information or employment, to give all such information it has to **Minnesota Life Insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any medical or health history including all consultations, diagnoses, prescriptions, treatments, tests, as well as any information regarding alcohol or drug abuse, AIDS or AIDS-related conditions.

I authorize the Company to release any information relevant to my insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom I have coverage, or to any other public or private entity as may be required.

This authorization shall be valid for 24 months from date it is signed. I have read it and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time except to the extent that Minnesota Life has taken action in reliance upon the authorization prior to notice of revocation. Revocation of this authorization by me in writing shall be effective upon receipt by Minnesota Life.

SIGNATURE OF INSURED X	DATE SIGNED
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NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

ATTENDING PHYSICIAN'S STATEMENT HISTORY

PATIENT'S NAME	PATIENT'S DATE OF BIRTH
DATE ACCIDENT OCCURRED	DATE AMPUTATION OR LOSS OF SIGHT OCCURRED

LOCATION OF ACCIDENT (Work, etc.) DESCRIBE:

Has patient ever had same or similar condition or prior disabilities?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
At the time of the accident, amputation, or loss of sight, was the patient receiving care or treatment of any disease or illness?	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient's dismemberment, total and irrevocable loss of sight caused (directly or indirectly) by any physical or mental infirmity; illness or disease; self-inflicted injury; commission of a felony; drugs or poison taken voluntarily; bacterial infection; travel on any military aircraft; or war?	<input type="checkbox"/>	<input type="checkbox"/>

If answers to any of the above questions "yes", describe particulars in detail, including dates.

DISEMBLEMENT

Was there an amputation resulting in severance through or above the wrist or ankle joint? If "yes", give complete description of dismemberment.	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL AND IRREVOCABLE LOSS OF SIGHT

Did total and irrecoverable loss of sight occur as a result of the accident?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
Did total and irrecoverable loss of sight occur more than 180 days after the accident?	<input type="checkbox"/>	<input type="checkbox"/>

WHAT WAS VISION AT LAST OBSERVATION? (SNELLEN NOTATION)

WITH GLASSES	O.D.	O.S.	DATE
WITHOUT GLASSES	O.D.	O.S.	DATE

DATE CORRECTED VISION WAS IRRECOVERABLY REDUCED TO 20/200 OR LESS IN THE BETTER EYE

MONTH/DAY/YEAR O.D. O.S.

VISION CAN BE RESTORED IN WHOLE OR IN PART BY:

O.D. <input type="checkbox"/> LENSES	<input type="checkbox"/> TREATMENT	<input type="checkbox"/> OPERATION	<input type="checkbox"/> NOT RESTORABLE
O.S. <input type="checkbox"/> LENSES	<input type="checkbox"/> TREATMENT	<input type="checkbox"/> OPERATION	<input type="checkbox"/> NOT RESTORABLE

Please enclose copies of any visual fields testing that has been done.

PLEASE INCLUDE COPIES OF YOUR MEDICAL RECORDS PERTAINING TO THE LOSS

NAME OF ATTENDING PHYSICIAN (Please print)	DEGREE	TELEPHONE NUMBER ()
PHYSICIAN'S ADDRESS (Street, City, State, Zip)		

SIGNATURE OF ATTENDING PHYSICIAN X	DATE SIGNED	PRINT NAME OF PERSON COMPLETING THIS FORM
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