



Accidental Dismemberment Claim Statement

ASSURANT

Employee
Benefits

☞ If you live in the state of Arizona, the following statement applies to you:

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.

☞ If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:

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.

☞ If you live in the state of California, the following statement applies to you:

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.

☞ If you live in the state of Colorado, the following statement applies to you:

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.

☞ If you live in the District of Columbia, the following statement applies to you:

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.

☞ If you live in the state of Florida, the following statement applies to you:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

☞ If you live in the state of New Jersey, the following statement applies to you:

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

☞ If you live in the state of Oregon, the following statement applies to you:

Any person who, with 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 may be guilty of insurance fraud.

☞ If you live in a state other than mentioned above, the following statement applies to you:

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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company. In this document, the terms "we," "us," "our," and the like, refer to each as applicable.

Accidental Dismemberment Claim Statement



Part 1—To be completed by the Insured

| | | |
|---|--|--|
| 1. Full name of insured (<i>first, middle, last—please print</i>) | | 2. Physicians consulted because of these injuries Names Addresses |
| 3. Full address (<i>street, city, state</i>) | | |
| 4. Phone number | 5. Date of birth | |
| 7. Social Security number | | 6. Describe in detail how and where the accident happened. (<i>Attach newspaper clipping, if possible.</i>) |
| 8. Name and address of employer | | |
| 9. Date of accident | 10. Was the accident sustained in the course of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. On what date were you first treated by a physician on account of these injuries? |

Part 2—To be completed by Attending Physician

| | | |
|--|---|---|
| 1. Patient's name | | 2. Was the loss sustained due solely to this accident? <input type="checkbox"/> Yes If "No," please give details of any contributory causes. <input type="checkbox"/> No |
| 3. Date of accident | 4. Date patient first consulted you for injuries resulting from this accident | |
| 5. As a result of this accident, did the patient suffer the loss of: <input type="checkbox"/> Right hand? Give the anatomical location of amputation and date performed. <input type="checkbox"/> Left hand? <input type="checkbox"/> Right foot? <input type="checkbox"/> Left foot? <input type="checkbox"/> Sight of right eye? <input type="checkbox"/> Sight of left eye? Is loss of sight total and irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give date loss of sight became total and irrecoverable. Give details if sight can be restored to either eye. | | 6. Final diagnosis, including complications |
| | | 7. Additional remarks |

Physician's name _____ Degree/Specialty _____

Address _____
STREET ADDRESS CITY STATE ZIP

Telephone no. _____ Fax no. _____

Signature _____ Date _____ Physician's EIN or SSN _____

NOTE: When Parts 1 and 2 of this form have been completed by you and your physician, please forward it to the policyholder/employer. Please make sure you have signed the Authorization Section on the last page.

AUTHORIZATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Union Security Insurance Company or an agent, attorney, consumer reporting agency, or independent administrator, acting on its behalf, information concerning advice, care, or treatment provided the insured named below or spouse or minor children thereof. This may include information relating to mental illness, use of drugs, or use of alcohol. I also authorize any employer, group policyholder, or benefit plan administrator to provide Union Security Insurance Company with financial or employment related information.

I understand that the information authorized herein will be used by Union Security Insurance Company to evaluate a claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. Information obtained will not be released to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

This authorization is valid from the date signed for the duration of the claim.

Full address _____ Insured's signature _____ DATE _____
_____ Dependent's signature _____ DATE _____
(if 18 or older)

Part 3—To be completed by Employer

| | | | |
|--|---------------------|--|--|
| 1. Full name of insured <i>(Please print.)</i> | | 2. Certificate number | 3. Effective date of insurance |
| 4. Date employed | 5. Date last worked | 6. Reason for not working after this date | |
| 7. Occupation, position or title | | 8. Basic salary rate as of the determination date specified in the policy. \$ _____ per _____ | 9. Amount being claimed <i>(1/2 dismemberment coverage)</i> \$ _____ |
| 10. Was insurance in force when injuries were sustained? <input type="checkbox"/> Yes <i>(If "No," give date and reason for termination.)</i> <input type="checkbox"/> No | | 11. Did injuries arise out of, or in the course of, the employment of the insured? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If "Yes," please explain.)</i> | |
| 12. Have you any additional information relating to this claim? _____ _____ | | | |

13. We hereby certify that the above facts are true to the best of our knowledge.

Policy no. _____
Participation no. _____ Name of employer _____
Account no. _____ Branch or affiliate _____

AUTHORIZED SIGNATURE

IMPORTANT FORM W-9 NOTICE

Under Federal law every financial institution that pays you interest is required to have you certify 1) your Social Security number *(or other taxpayer identification number)* and 2) whether or not the Internal Revenue Service has notified you that you are subject to Backup Withholding Order on interest and dividends. **It is very important to you** that we have your **Social Security number** *(or other taxpayer identification number)* and **Backup Withholding status** certification.

Although everyone must file a certification like the form below *(if you do not, the IRS can subject you to a \$50 penalty)*, you are not subject to a Backup Withholding Order unless you have been so notified by the IRS. If you do not file a certification, the IRS automatically requires all financial institutions to withhold at least 31% of all interest and dividends they credit to your account, and send the money to the IRS as a prepayment of your possible tax liability.

Please **immediately** complete the form below, sign it, and return it to us with the completed claim form. If you do not have a Social Security number *(or other taxpayer identification number)*, it is easy to apply for one at a local Social Security office.

**Life Benefit Center
Substitute Form W-9**

**Certification Form of
Taxpayer Identification Number**

Insured employee's Social Security number *(or other taxpayer identification number)* _____

I certify, under penalty of perjury, that 1) the Social Security number or other taxpayer identification number given above is correct and 2) I have not been notified by the Internal Revenue Service that I am subject to a Backup Withholding Order on interest and dividends. *(If you have been notified, please cross out the portion of the sentence beginning with "2.")*

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Insured employee's signature _____ Date _____

Insured employee's name *(Please print.)* _____