GROUP LIFE DISMEMBERMENT CLAIM KIT
FOR PROCESSING OF AN ACCIDENTAL DISMEMBERMENT CLAIM

SOME NOTES REGARDING THE DISMEMBERMENT COVERAGE

IF AN INSURED HAS SUSTAINED A LOSS DUE TO AN ACCIDENT, A DISMEMBERMENT CLAIM SHOULD BE FILED. THE LOSS OF HANDS OR FEET MUST BE BY SEVERANCE AT OR ABOVE THE WRISTS OR ANKLES. THE LOSS OF SIGHT MUST BE TOTAL AND NOT RECOVERABLE.

INSTRUCTIONS FOR FILING A DISMEMBERMENT CLAIM

PLEASE SUBMIT THE FOLLOWING:

1. THE CLAIM FORM (PAGE 2) FULLY COMPLETED BY THE EMPLOYER AND THE INSURED.
2. THE ATTENDING PHYSICIAN'S STATEMENT (PAGE 3) SHOULD BE FULLY COMPLETED BY THE PHYSICIAN WHO CAN VERIFY THE ACCIDENTAL INJURY AND LOSS.
3. ATTACH TO THE CLAIM FORM ANY APPLICABLE REPORTS (POLICE, MEDICAL, ETC.) WHICH CAN SUPPORT THE CLAIM FOR DISMEMBERMENT BENEFITS.
4. HIPPA AUTHORIZATION FORM (PAGE 5) SHOULD BE FULLY COMPLETED BY THE INSURED.

THIS FORM MUST BE FULLY COMPLETED TO PREVENT UNNECESSARY TIME DELAY IN CLAIM PROCESSING

IF YOU SHOULD NEED ASSISTANCE IN THE COMPLETION OF THE CLAIM FORM
PLEASE CALL (781) 828-7000 EXT. 417

CL11(W)

Please see last page Fraud Notice

BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL ST, CANTON MA 02021
781-828-7000 or 1-800-669-2668

Group Dismemberment Claim

Employer's Statement

Name of Insured: ________________________________ Group Policy No: ____________ Div: __________

Address of Insured: ____ Certificate No: ________________

Is Insured still working? ☐Yes ☐No Date Insured Last Worked: ____________ (mo-day-yr) Amount of Insurance: Basic________________ Accidental: ____________

No. of Hours worked each week: ___________ Annual Earnings as of date last worked: ____________________

Was Insured an Employee at time of accident? ☐ Yes ☐ No Insured's Occupation: ____________________

Date Employed: _______________ (mo-day-yr) Date of Birth: _____________ (mo-day-yr) Effective Date of Insurance: __________ (mo-day-yr)

Was Insurance terminated prior to accident? ☐Yes ☐ No If yes, date of termination: ____________________ (mo-day-yr)

I hereby certify that the date through which premium for this Insured has been paid is: ____________________ (mo-day-yr)

____
Signature of Authorized Representative

____
Employer

____
Street City/Town State Zip

____
Area Code Telephone Ext.

Insured's Section

Date and Time of Accident________________________ Place of Accident__________________________________

Brief Description of ____

Names of PHYSICIANS and HOSPITALS where you received treatment

Name	Address	Dates

Certification – The above statements are true and complete to the best of my knowledge and belief.

Signature of Insured: ____ Date ___________________

Insured: ______________________________ Date of Birth: ______________________

Present Condition

Diagnosis: ____

Symptoms: ____

Tests Conducted: (i.e. x-rays, EKG, etc.) ______________________________

Medications Prescribed: ______________________________

Progress: ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

Names and Addresses of other Attending Physicians and Hospitals

Name Address

____

____

Medical History

Date Injury Began	Date of First Treatment	Date of Last Treatment
______________ (mo-day-yr)	______________ (mo-day-yr)	______________ (mo-day-yr)

Is this condition related to a prior condition? Yes ☐ No ☐ If yes, when treated? ______________ (mo-day-yr)

If Yes, please describe: ______________________________

Date condition(s) prevented the patient from performing **all** of the duties of his/her present occupation: __________ (mo-day-yr)

1. **DISMEMBERMENT** Describe actual place of severance: ______________________

2. **LOSS OF SIGHT**
   a. Is loss of sight due to injuries sustained in an accident? Yes ☐ No ☐
      If Yes, give date of injury______________ (mo-day-yr)
      If No, describe disease or infirmity affective injury: ______________________
   b. Is loss of sight entire and irrecoverable? Yes ☐ No ☐
      If yes, give exact date it occurred ______________ (mo-day-yr)
      If no, is it anticipated? Yes ☐ No ☐ When (approximate date)? ______________
   c. Is a corneal transplant or other surgery or treatment contemplated to recover all or any part of this lost sight?
      Yes ☐ No ☐ If Yes, state when and explain fully.______________________
      ____
   d. Status of vision prior to injury Right Eye ____/____ Left Eye ____/____
   e. Present status of vision Right Eye ____/____ Left Eye ____/____
   f. Describe any disease or infirmity affecting sight prior to injury. ______________________

Date: ______________________ **Signature:** ______________________

Physician's Full Name: ______________________ **Telephone No:** ______________________

Address: ____

BOSTON MUTUAL LIFE INSURANCE COMPANY
REQUIRED FRAUD NOTICES - Applications & Claim Forms

STANDARD NOTICE:
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.

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

Notice to Maine Residents:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company. Penalties include imprisonment, fines or a denial of insurance benefit.

Notice to New Jersey Residents:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon Residents:
Any person who with intent to defraud or knowing that he or she 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.

Notice to Virginia Residents:
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 may have violated state law.

Notice to California Residents:
For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.