# Participant Accident
# Death, Dismemberment, Injury and/or Sickness
# Claim Form

THE HARTFORD

## IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

**To the Policyholder and Participant/Beneficiary, as applicable:**
We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms. Also, please read the "Important Notice" on page 4.

**The information below constitutes a complete claim filed with The Hartford for purposes of claiming Participant Accident benefits.**

### Part I – Policyholder's Statement (for All claim filings)

☐ Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.

☐ If filing is for a death claim, a certified copy of the Death Certificate stating cause and manner of death must be attached to this form.

☐ If filing is for a death claim, the claim must be submitted along with the beneficiary designation form(s) on file with the Policyholder/Plan, if any. If none on file, the Policyholder/Plan shall certify to that fact on the claim form.

### Part II – Beneficiary's Statement (for Death claims – also refer to Miscellaneous section)

☐ If more than one beneficiary, the beneficiaries may sign and date one form, or each may complete separate forms, showing their current address, date of birth, and Social Security Number.

### Part III – Claimant's Statement (for All claim filings – also refer to Miscellaneous section)

☐ Must be completed by claimant or beneficiary when claiming benefits for any type of loss.

### Part IV – Attending Physician's Statement (for Dismemberment/Sight/Hearing/Speech/Injury/Sickness claims)

☐ Complete the top portion of the Attending Physician's Statement, pages 7 and 8, for above losses. Provide both pages to your physician and request that they be completed and returned to The Hartford.

### Miscellaneous – All Claims

☐ Please sign the Medical Release of Information Authorization, page 5.

☐ Furnish, if available, police, motor vehicle Accident/Incident reports, autopsy/toxicology, trip itinerary and other pertinent information regarding your claim.

☐ If the claim proceeds are payable to an Estate, Part II and/or Part III must be completed by the Executors or Administrators of the Estate. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.

☐ If any beneficiary is a minor, part II and/or III must be completed by a custodian or guardian. Include the minor's Social Security Number. Also, please include a copy of the minor's birth certificate. An official certificate of the guardian's legal appointment and qualification of the minor's estate or property must also be included, if applicable.

☐ Foreign Death – include both the Official Death Certificate and the Death of American Citizen Abroad form. Please note that additional documents may be required upon claim review.

Submit claim by mail to: The Hartford
Group Life Claims
P.O. Box 14299
Lexington, KY 40512-4299
Fax to: 1-866-954-2621
E-Mail to: gbclaimcslife@thehartford.com
Phone: 1-888-563-1124

**Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization.**

**Participant Accident**
**Death, Dismemberment, Injury and/or Sickness**
**Claim Form**

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**PART I – POLICYHOLDER'S STATEMENT – TO BE COMPLETED FOR ALL CLAIMS**

| | | | |
|---|---|---|---|
| Policy Number:<br>41-BSR-101246 | Policyholder Name:<br>Billings Public Schools | | |
| Policyholder Email Address: | | | Policyholder Phone Number:<br>( ) |
| Policyholder Address (Street, City, State, & Zip Code): | | | |
| Insured Name: | | Insured DOB: | Insured Social Security Number: |
| Insureded Address (Street, City, State, & Zip Code): | | | |
| **FOR DEPENDENT CLAIM ONLY:** | | | |
| Dependent Name: | | Dependent DOB: | Dependent Social Security Number: |
| Dependent Address (Street, City, State, & Zip Code): | | | |
| Relationship to Employee:<br>☐Spouse<br>☐Dependent Child | If Dependent child benefits are claimed, was the child a full-time student? ☐Yes ☐No<br>If Yes, as required, include enrollment verification from school. | | Was dependent child incapacitated?<br>☐Yes ☐No |
| Benefits Claimed for:☐Death ☐Dismemberment ☐Injury ☐Sickness<br>☐Loss of Sight/Hearing/Speech ☐Paralysis ☐Loss of Use | | | Amount Claimed:<br>$ |
| Describe the covered activity in which the Insured was participating: | | | |
| Date of Death (if applicable): | Nature of Injury(ies) (if applicable): | | Nature of Sickness (if applicable): |
| Date of Accident/Onset Date: | Time of Accident/Onset (hh:mm)<br>☐AM ☐PM | Place of Accident/Onset of Symptoms: | |
| Fully describe the circumstances of the Accident or Onset of Symptoms (Use a separate sheet of paper, if necessary): | | | |

Injury/Sickness-related Benefit Information:
*Please check each benefit requested as a result of the Covered Injury and/or Sickness. If any previous claims have been submitted for this Covered Loss, only check the benefits that are applicable to this new claim. Benefits listed below may not be included in all certificates/policies. Refer to the certificate available for all available benefits, limitations and exclusions. All relevant supporting documentation should be included with this claim submission to help prove the claim.*

| | | | |
|---|---|---|---|
| ☐Accidental Needlestick | ☐Concussion | ☐HIV | ☐Vision Impairment |
| ☐Brain Damage | ☐Cosmetic Disfigurement/Severe Burn | ☐Hospital Indemnity | |
| ☐Catastrophic Injury Cash | ☐Family Expense | ☐Occupational Retraining | |
| ☐Coma | ☐Health Insurance Premium | ☐Post-Traumatic Stress Disorder | |

Is there a Beneficiary Designation on file? ☐ Yes ☐ No If Yes, please attach and return with this claim form.
Are there any absolute assignments on file? ☐ Yes ☐ No If Yes, please explain:

**POLICYHOLDER CERTIFICATION – TO BE COMPLETED FOR ALL CLAIMS (SIGNATURE REQUIRED)**

I hereby certify the insured is a member of the group insured under the above Policy and the loss was sustained under adequate supervision while participating in an official Covered Activity.

I further certify that the information provided on the Policyholder's Statement is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, Hartford Fire Insurance Company and/or its representative.

| Title of Policyholder Official | Signature of Policyholder Official | Date |
|---|---|---|
| | | |

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## PART II - Insured/Beneficiary Statement

**Name of Insured:** _____ **Policy Number(s):** _____

**Claim Number (if known):** _____

**Under penalties of perjury, I certify that:**

**(1)** the number shown on this form is my correct taxpayer identification; and

**(2)** I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and

**(3)** I am a U.S. person (including a U.S. resident alien).

**Certification Instructions:** You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.

**By signing below:**

**(1)** **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 4 of this claim form package.

**(2)** **I understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

### NOTICE: INSURED/BENEFICIARY LOCATED OUTSIDE THE UNITED STATES

For all insureds/beneficiaries located outside the United States, if stated under the policy or in an agreement, benefit payments will be made in U.S. dollars to the Policyholder, located in the United States, in trust for the sole use and benefit of the insured/beneficiary.
The Policyholder will transmit the payment to the insured/beneficiary promptly.

| Insured/Beneficiary Name: (print) | Date of Birth: | Relationship: |
|---|---|---|
| Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN) | | |
| Complete Mailing Address: (Number & Street) | Beneficiary's Social Security Number or Estate /Trust Tax ID: | |
| (City, State & Zip Code) | Telephone Number: Day: ( ) Evening: ( ) | |

Personal Cell Telephone Number: (_____)_____ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial:_____ to confirm your election

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

| *Signature:* X | Date: | E-mail address: |
|---|---|---|

### NOTICE: INSURED/BENEFICIARY LOCATED OUTSIDE THE UNITED STATES

For all insureds/beneficiaries located outside the United States, if stated under the policy or in an agreement, benefit payments will be made in U.S. dollars to the Policyholder, located in the United States, in trust for the sole use and benefit of the insured/beneficiary.
The Policyholder will transmit the payment to the insured/beneficiary promptly.

| Insured/Beneficiary Name: (print) | Date of Birth: | Relationship: |
|---|---|---|
| Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN) | | |
| Complete Mailing Address: (Number & Street) | Beneficiary's Social Security Number or Estate /Trust Tax ID: | |
| (City, State & Zip Code) | Telephone Number: Day: ( ) Evening: ( ) | |

Personal Cell Telephone Number: (_____)_____ May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail: ☐ Yes ☐ No Please initial:_____ to confirm your election

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

| *Signature:* | Date: | E-mail address: |
|---|---|---|

# IMPORTANT NOTICE

**Please read the statement that applies to your state of residence and sign the bottom of the page.**

**For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon Pennsylvania, Puerto Rico, Tennessee and Washington:** 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.

**For Residents of Arizona:** For your protection, Arizona 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 subject to criminal and civil penalties.

**For Residents of California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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 Colorado:** 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**For residents of Florida:** 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.

**For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

**For residents of Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

**For residents of 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 residents of New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading nformation is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

**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 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**For residents of Oregon:** 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

**For residents of Pennsylvania:** 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For residents of Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**For residents of Virginia:** Any person who, with the 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 have violated the state law.

Signature _____ Date _____

## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

**To:** Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. **I AUTHORIZE** you to disclose to The Hartford[1] a complete copy of, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, or privileged information, records, or documents relative to:

| Insured's Name (*Please print*) | Date of Birth | Last 4 Digits of Social Security Number |
|---|---|---|
| | | |

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefit s and/or leave request and/or request for accommodation. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

**I UNDERSTAND** that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

**I ALSO UNDERSTAND** that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make, unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory complaints, or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control

| Signature of Insured, Beneficiary or Authorized Representative | Date (Valid for 2 years) | Relationship to Insured ***(if signed by Authorized Representative)*** |
|---|---|---|
| | | |

[1] The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries and their affiliates

**Participant Accident**

**Death, Dismemberment, Injury and/or Sickness Claim Form**

**Mail forms to: The Hartford**
**Group Life Claims**
**P.O. Box 14299**
**Lexington, KY 40512-4299**
**Fax: 1-866-954-2621**
**E-Mail: gbclaimcslife@thehartford.com**

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**PART III – CLAIMANT'S STATEMENT –TO BE COMPLETED FOR ALL CLAIMS**

**INSTRUCTIONS:** Complete this form when applying for Death, Dismemberment, Injury and/or sickness benefits due to participation in a covered activity. If a question does not apply, please indicate "N/A".

| Policy Number: | Policyholder Name: | |
|---|---|---|
| Insured Name: | Insured DOB: | Insured Social Security Number: |
| Name of Deceased or Injured (if different from above): | Deceased/Injured DOB: | Deceased/Injured Social Security Number: |
| Address of Deceased/Injured *(Street, City, State, & Zip Code)* (if different from above): | | Relationship to Insured: ☐ Spouse ☐ Child |

Benefits Claimed for: ☐ Death ☐ Injury ☐ Sickness ☐ Dismemberment ☐ Paralysis ☐ Loss of Use ☐ Loss of Sight/Hearing/Speech

| Nature of Injury(ies) (if applicable): | Nature of Sickness (if applicable): | |
|---|---|---|
| Date of Accident/Onset Date: | Time of Accident/Onset (hh:mm): ☐AM ☐PM | Place of Accident/Onset of Symptoms: |

Fully describe the circumstances of the Accident or onset of symptoms (Use a separate sheet of paper, if necessary):

| Name and address of law enforcement agency involved: | Case Number: |
|---|---|

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If "Yes," what is the status of the claim?

Prior to the incident, did the Insured/Deceased/Injured have any chronic disease or physical defect or deformity? ☐ Yes ☐ No
If "Yes," describe in detail:

List all Healthcare Providers consulted for care due to this injury/sickness/death:

| NAME | ADDRESS | PHONE NUMBER | PERIOD TREATED |
|---|---|---|---|
| | | | From: To: |
| | | | From: To: |
| | | | From: To: |

List all hospitals where confined for care due to this injury/sickness/death:

| NAME | ADDRESS | PHONE NUMBER | PERIOD CONFINED: |
|---|---|---|---|
| | | | From: To: |
| | | | From: To: |
| | | | From: To: |

**PLEASE ATTACH COPY OF ITEMIZED HOSPITAL BILL, UB92 OR MEDICARE SUMMARY (if applicable)**

Did accident result in death? ☐ Yes ☐ No If "Yes," on what date: _____
Was autopsy performed? ☐ Yes ☐ No If "Yes," provide name/address/telephone number of coroner, if known:

Was an inquest held? ☐ Yes ☐ No If "Yes," verdict?

| Claimant's Name: | Date of birth: | Relationship to Insured/deceased/ injured: |
|---|---|---|
| Claimant's Address: *(Street, City, State, & Zip Code)* | | Claimant's E-mail Address: |

Phone Numbers:
Daytime: (____) _____ Evening: (____) _____ Personal Cell Phone: (____) _____
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No
and/or request this by E-mail? ☐ Yes ☐ No Please initial to confirm your election:

| SIGNATURE OF PERSON COMPLETING THIS FORM: | DATE: |
|---|---|

(Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)
Please sign and date the Medical Release of Information Authorization on page 5.

**DISMEMBERMENT, SIGHT, HEARING, SPEECH, INJURY, AND OR SICKNESS FILING ONLY**

**PART IV – ATTENDING PHYSICIAN'S STATEMENT**

**Mail forms to: The Hartford**
**Group Life Claims**
**P.O. Box 14299**
**Lexington, KY 40512-4299**
**Fax: 1-866-954-2621**
**E-Mail: gbclaimcslife@thehartford.com**

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**Please print – Use a separate sheet of paper, if necessary**
**(Physician's Certification on Page Two)**



| Name of Patient: | Date of Birth: | Social Security Number: | |
|---|---|---|---|
| Address: | City: | State: | Zip Code: |

Nature of condition(s) resulting from the incident: *(Check all that apply)*
☐ Injury ☐ Sickness ☐ Dismemberment ☐ Paralysis ☐ Loss of Use ☐ Loss of Sight/Hearing/Speech

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
If "Yes," by whom?

Is patient still under your care for this condition? ☐Yes ☐No If "no," provide date your services terminated:

**Injury Information**
If condition is result of injury, please provide information as noted below.

Provide a description of the injuries received by the patient in the accident, the primary diagnosis, and the affected body part(s):

| Date of injury: | Date patient first examined by you for this injury: |
|---|---|

What complications, if any, have arisen?

Had patient previously had medical attention for this injury? ☐ Yes ☐ No
If "Yes," by whom?

Was the injury described above, or itself, and independent of all other causes, solely responsible for the loss? ☐ Yes ☐ No
If "No," give the particulars of any contributing cause(s):

Was claimant under the influence of alcohol and/or other drugs at the time of accident or injury? ☐Yes ☐No ☐Unknown

Was surgery performed due to the injury? ☐Yes ☐No Date of surgery:_____
Name of surgeon:

**Sickness Information**
If condition is a sickness, please provide information as noted below.

Provide the primary diagnosis and description of the of the patient's symptoms:

| Onset date: | Date patient first examined by you for this sickness: |
|---|---|

What complications, if any, have arisen?

Had patient previously had medical attention for this sickness? ☐Yes ☐No If "Yes," by whom?

**Hospital Information**
Was the patient confined to a hospital due to the injury/sickness? ☐Yes ☐No If "Yes," please provide information as noted below.

Hospital Name:

Hospital Address:

| Date of Admission: | Date of Discharge: | Reason for Hospitalization: | ☐Inpatient ☐Outpatient |
|---|---|---|---|

Hospital Name:

Hospital Address:

| Date of Admission: | Date of Discharge: | Reason for Hospitalization: | ☐Inpatient ☐Outpatient |
|---|---|---|---|

**Coma -** Means complete unconsciousness with inability to respond to external or internal stimuli for a continuous period.
Did patient's injury/sickness result in a Coma? ☐Yes ☐No If "Yes," please provide information as noted below.

| Date Coma Began: | Date Coma Ended: | If Coma has not ended, Current Duration (days): |
|---|---|---|

Was the Coma confirmed by EEG? ☐ Yes ☐ No

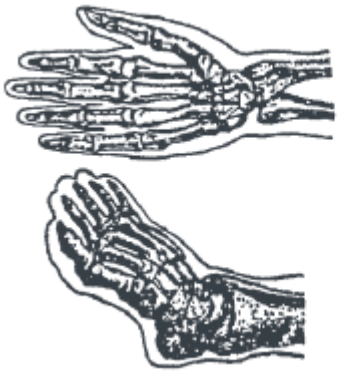
Note: Continue on next page for other losses.

**ATTENDING PHYSICIAN'S STATEMENT – Cont.** **Page Two**

**Accidental Dismemberment, Paralysis and/or Loss of Use**

If the injury described above caused an amputation or loss of body usage, is this amputation or loss irrecoverable? ☐Yes ☐No

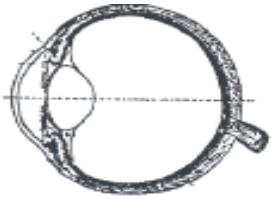
If "No," please explain: _____



Please indicate location of amputation or area of injury on the left side chart. Add any necessary comments below:

**Loss of Sight**

If the injury described above caused loss of sight, please provide copies of vision test and complete below.



Indicate visual acuity prior to accident:

| | | |
|---|---|---|
| Right eye: | Corrected | Uncorrected |
| Left eye: | Corrected | Uncorrected |

Indicate best corrected visual acuity and/or area of injury as of date of last examination on _____ (date).

| | | |
|---|---|---|
| Right eye: | Corrected | Uncorrected |
| Left eye: | Corrected | Uncorrected |

Is this loss of sight (due to injury) irrecoverable?
☐Yes ☐No

**Loss of Hearing**

In your medical opinion, has this patient sustained complete and irrecoverable hearing loss due to an injury?
☐Yes ☐No ☐Right ☐Left ☐Both

Please provide copies of auditory test results.

**Loss of Speech**

In your medical opinion, has this patient sustained complete and irrecoverable loss of speech due to an injury?
☐Yes ☐No

Please provide copies of speech test results.

**Healthcare Provider Information and Certification**

| | | | |
|---|---|---|---|
| Healthcare Provider Name (please print): | | | |
| Specialty: | License Number: | EIN/Tax ID# or SSN: | |
| Street Address: | City/Town: | State: | Zip Code: |
| Telephone Number: ( ) | Fax Number: ( ) | | |
| Physician's Signature: | | Date: | |