UNICARE®

RESET

Accidental Dismemberment or Loss of Sight Claim

INSTRUCTIONS

As soon as you learn that an insured person has suffered any of the losses covered under the policy, this form (completed by the policyholder, claimant and the attending physician) should be sent to Life Claims Service Center, P.O. Box 105448, Atlanta, GA 30348-5448

Include the following material:
(a) Enrollment card
(b) All available newspaper clippings pertaining to the injury and loss, and a police or accident report, if available.

SECTION A STATEMENT OF EMPLOYER

GROUP NUMBER	PCC	CLAIM BR.	Optional, additional, or supplemental (if different than basic)	PCC	CLAIM BR.	or	CASE NUMBER	GROUP NUMBER	SUFFIX NO.

NAME OF EMPLOYEE	ADDRESS OF EMPLOYEE (NO., STREET, CITY, STATE, ZIP CODE)

DATE ENTERED FULL-TIME EMPLOYMENT	DATE LAST FULL-TIME EMPLOYMENT	OCCUPATION / CLASSIFICATION	DATE LAST WORKED	AMOUNT OF BENEFIT
				$

WAS COVERAGE CONTINUED TO DATE OF ACCIDENT ON A PREMIUM PAYING BASIS? ☐ YES ☐ NO	IF "NO" WHAT WAS THE DATE OF LAST PREMIUM PAYMENT	EARNINGS AT DT LAST WORKED	ORIG. EFF DATE OF EE INS.

DATE OF ACCIDENT	TIME OF ACCIDENT	PLACE OF ACCIDENT	DID ACCIDENT OCCUR IN COURSE OF EMPLOYMENT? ☐ YES ☐ NO

It is hereby certified that the statements contained above are true to the best of my knowledge and belief.

NAME OF EMPLOYER	EMPLOYER'S PHONE NO.

ADDRESS OF EMPLOYER

NAME OF PERSON AUTHORIZED (Please Print)	AUTHORIZED SIGNATURE / TITLE	DATE

GROUP INSURANCE APPLICATION AND RECORD CARD SHOULD ACCOMPANY THIS FORM

SECTION B STATEMENT OF EMPLOYEE

NAME	SOCIAL SECURITY NO.	DATE OF BIRTH

LEGAL ADDRESS	EMPLOYEE'S TELEPHONE NO.

DATE OF INJURY	DATE OF LOSS	DATE FIRST TREATED BY PHYSICIAN	NAME AND ADDRESS OF ATTENDING PHYSICIAN

EXTENT OF LOSS

DESCRIBE IN DETAIL HOW ACCIDENT OCCURRED

I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital, physician or any other institutions or person who has attended or examined me to disclose to Healthy Alliance Life Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I am willing that a photostat of this authorization be accepted with the same authority as the original.

EMPLOYEE SIGNATURE DATE

THE FURNISHING OF FORMS DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY ON THE PART OF THE COMPANY (over)

FOR HEADQUARTERS USE

CLAIM NO.	EXAMINER	BRANCH	TOTAL BENEFIT	DATE APPROVED / DENIED

PROOF OF ACCIDENTAL DISMEMBERMENT
ATTENDING PHYSICIAN'S STATEMENT

INSTRUCTIONS TO PHYSICIAN

RESET

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH

1. (A) WHEN DID THE ACCIDENT HAPPEN? DATE .....
   (B) WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE .....
   (C) HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐ IF "YES" STATE WHEN AND DESCRIBE
2. WAS THE LOSS SOLELY THE RESULT OF AN ACCIDENTAL INJURY? YES ☐ NO ☐ IF "NO", WHAT DISEASE OR CONDITION WAS A CONTRIBUTORY CAUSE? .....
   .....
3. IS THE PATIENT COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF THE PROCEEDS THEREOF? YES ☐ NO ☐

TO BE COMPLETED FOR LOSS OF SIGHT

(4-S) DID THE ACCIDENTAL INJURY RESULT IN THE TOTAL AND IRRECOVERABLE LOSS OF SIGHT OF --

RIGHT EYE YES ☐ NO ☐ DATE OF LOSS .....
WAS THE EYE ENUCLEATED? YES ☐ NO ☐ DATE .....
LEFT EYE YES ☐ NO ☐ DATE OF LOSS .....
WAS THE EYE ENUCLEATED? YES ☐ NO ☐ DATE .....

(5-S) STATE THE DATE YOU FIRST DETERMINED THAT CENTRAL VISUAL ACUITY WAS IRRECOVERABLY REDUCED TO 20/200 OR LESS WITH CORRECTION:

_____ O.D.
MONTH DAY YEAR

_____ O.S.
MONTH DAY YEAR

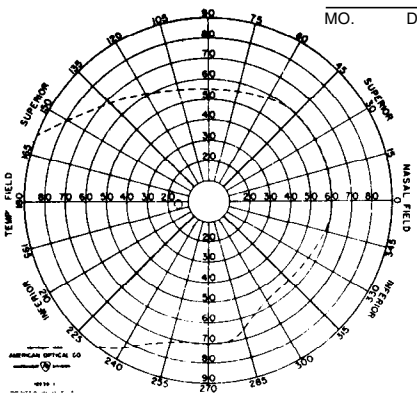
SNELLEN NOTATIONS ON THAT DATE:

	UNCORRECTED	CORRECTED
O.D.V.		
O.S.V.		

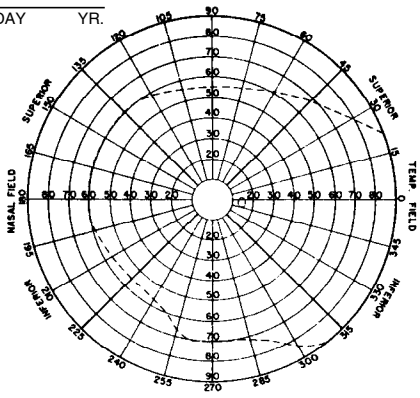
IF CORRECTED CENTRAL VISUAL ACUITY IS GREATER THAN 20/200, INDICATE VISUAL FIELDS BELOW:

DATE OF TEST:

MO. DAY YR.



NO. 480Y PERIMETER CHART (LEFT)



NO. 480Y PERIMETER CHART (RIGHT)

(6-S) CAN USEFUL VISION LIKELY BE RESTORED BY MEDICATION OR SURGERY? YES ☐ NO ☐
IF "YES", WHAT ARE THE PROSPECTS?

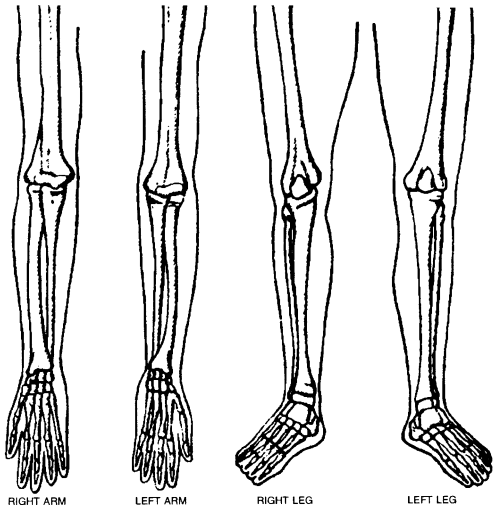
TO BE COMPLETED FOR LOSS OF LIMB(S)

(4-L) DID ACCIDENTAL INJURY RESULT IN LOSS OF LIMBS
YES ☐ NO ☐

(5-L) WHAT LIMBS HAVE BEEN SEVERED:

	DATE OF SEVERANCE
☐ RIGHT HAND	MO. DAY YR.
☐ LEFT HAND	MO. DAY YR.
☐ RIGHT FOOT	MO. DAY YR.
☐ LEFT FOOT	MO. DAY YR.

(6-L) PLEASE INDICATE EXACT POINT OF SEVERANCE



I certify that the above answers and statements are true and complete according to the best of my knowledge and belief.

Date | Signature (Attending Physician) | Degree | Telephone

Print Name of Physician

Street Address | City or Town | State or Province | Zip Code

PATIENT IS RESPONSIBLE FOR ANY EXPENSE INVOLVED IN THE COMPLETION OF THIS FORM