PACIFIC GUARDIAN LIFE

RESET

CLAIM FOR GROUP ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT BENEFITS

For your protection California laws and the laws of some states require 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.

CLAIMANT'S STATEMENT - COMPLETE IN FULL

Name of Employee	Policy No.	❑ Married ❑ Single
Address (Street, City, State, Zip)	Social Security No.	Date of Birth
Employer	Address (Street, City, State, Zip)	
State Fully How Accident Occurred		Date of Accident
Describe Fully How Accident Occurred		Time of Accident
Did Accident Occur on the Job? ❑ Yes ❑ No	Is Claim Covered by Workers' Compensation Act or Similar Law? ❑ Yes ❑ No	

COMPLETE APPROPRIATE SECTION

A. LOSS OF SIGHT BENEFITS

Which Eye was Injured? ❑ Left ❑ Right ❑ Both	Date you Lost Entire Vision in Eye ❑ Left ❑ Right
Have you had any Disease or Injury to either Eye before? ❑ Yes ❑ No If so, give date and nature of disease or injury;	
REMARKS:	

Date First Treated by Physician	Name of Physician	Address (Street, City, State, Zip)
Date Other Physician Consulted	Name of Physician	Address (Street, City, State, Zip)

B. DISMEMBERMENT BENEFITS

Which Limb was Amputated?	Date of Amputation
Had this Limb been Injured before? ❑ Yes ❑ No If so, give date and nature of injury:	
REMARKS:	

I hereby authorize any hospital, physician, or surgeon to furnish Pacific Guardian Life Insurance Company any information desired on the above-named patient. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of the Insured Date:

POLICYHOLDER'S VERIFICATION

Insured's Full Name			Last Date Worked	Date Returned to Work	Occupation
Class:	Policy No.:	Date Insured:	Employment date:	Termination Date :	Is claim covered by Workers' Compensation or Similar Act? ❑ Yes ❑ No

IF THIS IS A UNION OR TRUSTEE PLAN:

Date became a member:	Date membership terminated:	Was member in good standing at date of injury? ❑ Yes ❑ No
Is claimant eligible for benefits under the Health and Welfare Trust Fund? ❑ Yes ❑ No		
REMARKS		
Name of Policyholder		
Title	Signature	Date

Have your physician complete the Attending Physician's or Surgeon's Statement Section

ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for the completion of this form without expense to the Company.

Patient's Name	Date of Birth	Policy No.

Address (Street, City, State, Zip)

Date of Accident	Did Accident Arise Out of Patient's Employment? ❑ Yes ❑ No	Date of First Treatment	Date of Last Treated

History as to How Accident Occurred

Described the Exact Nature, Location and Extent of all Injuries Sustained (use REMARKS space if necessary)

Nature of Surgical Procedure, if any, (Copy of Operative Report may be attached)	Date Performed

COMPLETE APPROPRIATE SECTION

I. LOSS OF SIGHT

Visual Acuity Prior to Accident:

Visual Acuity at Present Time:

Is the Loss of Sight Entire and Irrecoverable?	Date Total Vision Lost:
O.S. ❑ Yes ❑ No / O.D. ❑ Yes ❑ No	O.S. _____ O.D. _____
If sight can be restored in either eye, give details	

II. LOSS OF LIMB

Did the Loss Occur at or Above the Wrist Joint? ❑ Yes ❑ No

Did the Loss Occur at or Above the Ankle Joint? ❑ Yes ❑ No

If "No", Describe Exact Level of Amputation

Was the Injury, by itself, Sufficient to Cause the Loss Described? ❑ Yes ❑ No

If "No", describe any Disease which Contributed to this Loss.

REMARKS

Date	Signature of Attending Physician	Degree

Address (Street, City, State, Zip)