



FORT DEARBORN LIFE
Insurance Company®

Toll Free: (800) 778-2281
Fax #: (972) 996-9361

Claim for Dismemberment Benefits

Submit to: Fort Dearborn Life Insurance Company®
Administrative Office:
P.O. Box 655403
Dallas, Texas 75265-5403

To be Completed by Employee or Employee's Legal Representative

Employee Name: _____ Employee ID: _____ Date of Birth ___ / ___ / ___

Policy No.: 38000 Sex: M F SSN: _____ Marital Status: Single Married Divorced Widowed

Complete the following only if this claim is for a dependent:

Dependent's Name: _____ Date of Birth: ___ / ___ / ___

SSN: _____ Sex: M F Relationship: _____

This claim is being made under: (Check one) Accidental Death and Dismemberment Supplement
 The Voluntary Accident Insurance Policy

Nature of Dismemberment — Loss of: (Check one)

<input type="checkbox"/> Right Hand	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Sight of Right Eye
<input type="checkbox"/> Left Hand	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Sight of Left Eye
<input type="checkbox"/> Both Hands	<input type="checkbox"/> Both Feet	<input type="checkbox"/> Sight of Both Eyes

Benefits are payable for specific losses only if covered by the Group Policy. See certificate of coverage for details.

Please describe how the accident occurred: (Include date and time, location, all pertinent details, names and addresses of witnesses):

Did the accident occur in the course of employment? Yes No

List the following information concerning practitioners who provided treatment in this loss:

Name	Date Seen	Telephone No.
_____	_____	_____
_____	_____	_____
_____	_____	_____

If hospitalized: Hospital: _____ Address: _____
Dates of Admission ___ / ___ / ___ to ___ / ___ / ___

AGREEMENTS AND AUTHORIZATION:

I, the undersigned claimant, have read and agree that the above statements and answers are furnished in support of my claim for benefits and are complete, true, and correctly recorded to the best of my knowledge and belief. I understand that incorrect or untrue answers on this form may result in denial of this claim and may be cause for expulsion from the Texas Employees Group Benefits Program.

I understand and agree that:

- This authorization is voluntary but that my signature is required in order for Fort Dearborn Life Insurance Company (the "Company") to evaluate my claim for benefits;
- If I refuse to sign this authorization, the Company has the right to deny my claim, or that of my dependents, if applicable;
- I may revoke this authorization at any time in writing but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation;
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy or facsimile of this authorization shall be as valid as the original;
- This authorization shall expire the later of 24 months from the date signed or at the end of any appeal process concerning my claim.

I, as well as any person authorized to act on my behalf or my personal representative, acknowledge the right, upon request, to obtain a true copy of this authorization from the Company.

I authorize my employer, the Employees Retirement System of Texas ("ERS"), and any medical professional, hospital, medical facility, medical provider, pharmacy, government agency, insurance carrier, HMO, MCO, or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to the Company's claims department or its authorized representative(s) any information relating to me, or my children if applicable, concerning advice, care or treatment, including any claims processed by Blue Cross Blue Shield of Texas, for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus), or other sexually transmitted diseases.

I authorize my employer, ERS, any government agency, or insurance carrier to disclose any information related to my employment or retirement and all other information necessary to process my claim.

WARNING: 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.



Signature of Employee: _____

Date: _____

Address: _____

Telephone No.:

() _____

To be Completed by Employer

Was employee on any type of leave on the date of dismemberment? Yes No

If Yes, please explain type of leave: _____ Insured Salary _____

What was the last date employee was actively at work? _____ Date of Hire _____

Group Name: _____

Group Address: _____

Signature of Insurance Representative ()
Phone Number and Extension

Attending Practitioner's Statement

1. Patient's Name _____ Date _____

a. Nature of Injury (Describe complications, if any) _____

b. Date Accident Occurred: _____

c. Is the claim made for a loss which is from illness, disease, bodily infirmity or any bacterial infection occurring from an accidental cut or wound, rather than from the injury sustained? Yes No

Loss of Bodily Member

2. a. If claim is being made due to loss of member, was the loss due to the injury sustained and not directly or indirectly from any disease or infirmity of mental or bodily nature? _____

b. Was an amputation performed at or above the wrist or ankle? Yes No
Date Performed _____

Right Hand Left Hand Right Foot Left Foot

Loss of Vision

3. a. If claim is being made for loss of Vision, please inform us of the patient's vision prior to injury:
Without glasses O.D. _____ O.S. _____ Date _____

With glasses/lens O.D. _____ O.S. _____ Date _____

b. Names and addresses of ophthalmologists, optometrists, or practitioners previously seen for eye care:

c. What was vision after injury?
Without glasses O.D. _____ O.S. _____ Date _____

With glasses/lens O.D. _____ O.S. _____ Date _____

d. What was vision after treatment?
Without glasses O.D. _____ O.S. _____ Date _____

With glasses/lens O.D. _____ O.S. _____ Date _____

e. Vision can be restored in whole or part by:
O.D. Lenses _____ Treatment _____ Operation _____ Not Restorable _____

O.S. Lenses _____ Treatment _____ Operation _____ Not Restorable _____

Estimated date vision could be expected to improve: _____

f. Is loss of vision entire and irrecoverable, beyond remedy by surgical or other means? (Explain)

Signature of Practitioner: _____ Date _____

Address: _____

Telephone No: () _____