Accidental Dismemberment Claim Statement

ASSURANT
Employee
Benefits

☞ **If you live in the state of Arizona, the following statement applies to you:**
For your protection Arizona Law requires the following statement 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.

☞ **If you live in the states of Arkansas, Louisiana or Texas, the following statement applies to you:**
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.

☞ **If you live in the state of California, the following statement applies to you:**
For your protection California law requires the following to appear on this form: 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.

☞ **If you live in the state of Colorado, the following statement applies to you:**
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 or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

☞ **If you live in the District of Columbia, the following statement applies to you:**
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

☞ **If you live in the state of Florida, the following statement applies to you:**
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

☞ **If you live in the state of New Jersey, the following statement applies to you:**
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

☞ **If you live in the state of New York, the following statement applies to you:**
Pursuant to Section 403(d) and Regulation 95 of the New York Insurance Law, the following statement applies to our accident and health policies only: 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 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.

☞ **If you live in the state of Oregon, the following statement applies to you:**
Any person who, with 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 be guilty of insurance fraud.

☞ **If you live in a state other than mentioned above, the following statement applies to you:**
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.

To avoid unnecessary delays, be sure all parts of the Claim Statement are completed according to the instructions, and DO NOT SEPARATE the pages.

In New York, insurance products are underwritten by Union Security Life Insurance Company of New York, which is licensed in New York and has its principal place of business in Syracuse, New York. In this document, the terms “we,” “us,” “our,” and the like, refer to each as applicable.

Union Security Life Insurance Company of New York
Administered by: **Assurant Employee Benefits** Life Benefit Center 2323 Grand Boulevard Kansas City Missouri 64108-2670
T 800.451.4531 F 816.881.8967

Accidental Dismemberment Claim Statement

ASSURANT Employee Benefits

Part 1—To be completed by the Insured

1. Full name of insured *(first, middle, last—please print)*

2. Physicians consulted because of these injuries
   Names   Addresses

3. Full address *(street, city, state)*

4. Phone number

5. Date of birth

6. Describe in detail how and where the accident happened. *(Attach newspaper clipping, if possible.)*

7. Social Security number

8. Name and address of employer

9. Date of accident

10. Was the accident sustained in the course of your employment?
    ☐ Yes ☐ No

11. On what date were you first treated by a physician on account of these injuries?

Part 2—To be completed by Attending Physician

1. Patient's name

2. Was the loss sustained due solely to this accident? ☐ Yes
   If "No," please give details of any contributory causes. ☐ No

3. Date of accident

4. Date patient first consulted you for injuries resulting from this accident

5. As a result of this accident, did the patient suffer the loss of:

   ☐ Right hand?
   ☐ Left hand?
   ☐ Right foot?
   ☐ Left foot?

   Give the anatomical location of amputation and date performed.

   ☐ Sight of right eye?
   ☐ Sight of left eye?
   Is loss of sight total and irrecoverable? ☐ Yes ☐ No
   If "Yes," give date loss of sight became total and irrecoverable.

   Give details if sight can be restored to either eye.

6. Final diagnosis, including complications

7. Additional remarks

Physician's name ______________________ Degree/Specialty ______________

Address ____
STREET ADDRESS   CITY   STATE   ZIP

Telephone no. ______________________ Fax no. ______________________

Signature ______________________ Date ____________ Physician's EIN or SSN ____________

NOTE: When Parts 1 and 2 of this form have been completed by you and your physician, please forward it to the policyholder/employer. Please make sure you have signed the Authorization Section on the last page.

AUTHORIZATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Union Security Life Insurance Company of New York or an agent, attorney, consumer reporting agency, or independent administrator, acting on its behalf, information concerning advice, care, or treatment provided the insured named below or spouse or minor children thereof. This may include information relating to mental illness, use of drugs, or use of alcohol. I also authorize any employer, group policyholder, or benefit plan administrator to provide Union Security Life Insurance Company of New York with financial or employment related information.

I understand that the information authorized herein will be used by Union Security Life Insurance Company of New York to evaluate a claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request. Information obtained will not be released to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with the claim.

This authorization is valid from the date signed for the duration of the claim. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Life Insurance Company of New York to use and disclose protected health information.

Full address ______________________ Insured's signature ______________________ DATE

______________________ Dependent's signature ______________________ DATE
(if 18 or older)

Part 3—To be completed by Employer

1. Full name of insured *(Please print.)*	2. Certificate number	3. Effective date of insurance

4. Date employed	5. Date last worked	6. Reason for not working after this date

7. Occupation, position or title	8. Basic salary rate as of the determination date specified in the policy. $ per	9. Amount being claimed *(1/2 dismemberment coverage)* $

10. Was insurance in force when injuries were sustained? ☐ Yes ☐ No *(If "No," give date and reason for termination.)*	11. Did injuries arise out of, or in the course of, the employment of the insured? ☐ Yes ☐ No *(If "Yes," please explain.)*

12. Have you any additional information relating to this claim?

13. We hereby certify that the above facts are true to the best of our knowledge.

Policy no. ______________________

Participation no. ______________________ Name of employer ______________________

Account no. ______________________ Branch or affiliate ______________________

Date ______________________ By ______________________ AUTHORIZED SIGNATURE

IMPORTANT FORM W-9 NOTICE

Under Federal law every financial institution that pays you interest is required to have you certify 1) your Social Security number *(or other taxpayer identification number)* and 2) whether or not the Internal Revenue Service has notified you that you are subject to Backup Withholding Order on interest and dividends. **It is very important to you** that we have your **Social Security number** *(or other taxpayer identification number)* and **Backup Withholding status** certification.

Although everyone must file a certification like the form below *(if you do not, the IRS can subject you to a $50 penalty)*, you are not subject to a Backup Withholding Order unless you have been so notified by the IRS. If you do not file a certification, the IRS automatically requires all financial institutions to withhold at least 31% of all interest and dividends they credit to your account,and send the money to the IRS as a prepayment of your possible tax liability.

Please **immediately** complete the form below, sign it, and return it to us with the completed claim form. If you do not have a Social Security number *(or other taxpayer identification number)*, it is easy to apply for one at a local Social Security office.

Life Benefit Center
Substitute Form W-9

Certification Form of
Taxpayer Identification Number

Insured employee's Social Security number *(or other taxpayer identification number)* ______________________

I certify, under penalty of perjury, that 1) the Social Security number or other taxpayer identification number given above is correct and 2) I have not been notified by the Internal Revenue Service that I am subject to a Backup Withholding Order on interest and dividends. *(If you have been notified, please cross out the portion of the sentence beginning with "2.")*

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

Insured employee's signature ______________________ Date ______________________

Insured employee's name *(Please print.)* ______________________