MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

GROUP ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT CLAIM FORM

This form should be prepared by the employee, his attending physician and employer, immediately after occurrence of an accident for which a claim is being submitted. Forward completed claim forms to above address.

Attach a separate statement if space provided on the form is inadequate for complete answers. By furnishing this claim form and investigating the claim, the insurance company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

INSURED'S STATEMENT

Name of Insured | Age

Where did injury occur? | Date & hour of injury

What were you doing?

Please describe the injury

Physicians Consulted	Name	Date	Address

Were you confined to a hospital? ☐ Yes ☐ No If Yes: Name of Hospital _____
Address _____

Dates From: Month Day Year To: Month Day Year

Names & addresses of two witnesses to the accident	Name	Address

Insured's Signature _____

Insured's Address _____ Date _____
Street City State Zip Month Day Year

EMPLOYER'S STATEMENT

Name of Insured | Social Security Number | Amount of Insurance $

Name of Employer | Group Number

Address of Employer | Date of Birth

Was Insured in your employ at time disability began? ☐ Yes ☐ No | Date Employed? Month Day Year

Date on which Insured last worked on full-time | When did Insured stop work? Month Day Year A.M. P.M.

When did Insured return to work? Month Day Year A.M. P.M. | If not back at work, when do you expect Insured to return? Month Day Year

Has Insured made claim for Workers Compensation? ☐ Yes ☐ No | Is Insured entitled to such benefits? ☐ Yes ☐ No

Did injury or illness arise out of or in the course of occupational employment for wages or profit? ☐ Yes ☐ No

Do you recommend payment of this claim? ☐ Yes ☐ No

Remarks:

Name of Authorized Individual (Type or Print) _____

Title or Position _____

Signature _____ Date _____
Month Day Year

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name		Age
Nature of injury (Describe complications, if any)		
Date of accident	Nature of surgical procedure, if any (Describe briefly)	
Date performed	Where performed	If in hospital ❑ Inpatient ❑ Outpatient

List Non-Surgical Treatments and Dates	Treatment	Date
List Additional Related Surgical Procedures and Dates	Procedure	Date

If disease, deformity, infirmity or intoxicant was a contributing factor to either the accident or the injury, please state how and to what extent

Have you furnished a similar report to any other insurance companies?
❑ Yes ❑ No If "Yes," please give names

Is loss of vision irrecoverable?
❑ Yes ❑ No Remarks:

Name of Physician (Type or Print) _____

Signature of Physician _____ Date _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

AUTHORIZATION

TO WHOM IT MAY CONCERN:

I hereby request and authorize you to furnish to the insurance company providing this form, or their representatives, any and all information you may have concerning any illness, or injuries I may have suffered, medical history, consultations, prescriptions or treatments, including x-ray plates, and copies of all hospital or medical reports, that the same may be included as part of the proofs for claim submitted to the company. A photostatic copy of this authorization shall be considered as effective or valid as the original.

_____ (Witness to Insured's Signature)

_____ (Signature of Insured)

Signed this the _____ day of _____ , 20 _____