American International Companies®
Insurance Company of the State of Pennsylvania

MAIL TO:

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
Email: claims@adventistrisk.org

Phone: (301) 453-7400
Fax: (301) 453-7060

PROOF OF LOSS–ACCIDENTAL DISMEMBERMENT/ PARALYSIS

NAME OF GROUP:

POLICY NUMBER:

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Claimant. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Claimant will be required to complete PART B. Be certain that PARTS C and D on the reverse side are completed in full and signed by the Claimant and Attending Physician, respectively. The Claimant is responsible for the completion of the Attending Physician's Statement without expense to the Company.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) Your company's enrollment benefits form; (2) Confirmation of employee's principal sum and current premium payment; (3) information on other insurance; (4) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of the trip, destination to and from trip, and confirmation that trip was authorized by the company.
Please provide company name, address, phone number, and policy number.
Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary.

Any person who knowingly and/or with intent to injure, defraud, or deceive an insurance company or other person files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS | DATE EMPLOYED

EMPLOYEE/MEMBER NAME AND ADDRESS | DATE OF ACCIDENT

EFFECTIVE DATE OF COVERAGE | EMPLOYEE/MEMBER SOCIAL SECURITY NUMBER | DATE OF BIRTH | EMPLOYEE/MEMBER OCCUPATION

TERMINATION DATE OF COVERAGE | INSURANCE CLASS | SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY) | DATE PREMIUM PAID TO

ACCIDENTAL DEATH BENEFIT IN FORCE | DATE OF LAST BENEFIT INCREASE BENEFITS? | IS EMPLOYEE/MEMBER RECEIVING W.C. ☐ YES ■ NO | IS EMPLOYEE/MEMBER RECEIVING ANY OTHER INSURANCE? ☐ YES ■ NO

IF EITHER ANSWER IS YES, INDICATE NAME OF COMPANY: | ADDRESS OF COMPANY

POLICY NUMBER | PHONE NUMBER | TYPE OF BENEFIT, BENEFIT AMOUNT, EFFECTIVE DATE

STATUS OF EMPLOYEE/MEMBER ON DATE LAST WORKED

☐ ACTIVE ☐ RETIRED ☐ PREMIUM WAIVER FOR DISABILITY ☐ APPROVED LEAVE OF ABSENCE (EXPLAIN) ☐ OTHER

DATE EMPLOYEE/MEMBER LAST WORKED | REASON EMPLOYEE/MEMBER DID NOT RETURN TO WORK

EMPLOYEE/MEMBER WAS: ☐ HOURLY ☐ SALARIED ☐ COMMISSIONED ☐ OTHER (EXPLAIN)

If Claim is For Dependent, Provide the Following:

DEPENDENT'S NAME AND ADDRESS | SOCIAL SECURITY NUMBER | RELATIONSHIP | AMOUNT OF BENEFIT

DEPENDENT'S OCCUPATION | DEPENDENT'S DATE OF BIRTH | NAME AND ADDRESS OF EMPLOYER

GROUP POLICYHOLDER/EMPLOYER SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED | PLACE (CITY, STATE) | PHONE NUMBER

GROUP POLICYHOLDER/EMPLOYER | BY (THEIR AUTHORIZED REPRESENTATIVE)

PART B: IMPORTANT TAX INFORMATION

To Be Completed by Claimant
Social Security Number/
Tax ID Number

Claimant

Please Print or Type Name of

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

Be Certain Part C on the Reverse Side is Completed

PART C: CLAIMANT INFORMATION

WHEN DID ACCIDENT HAPPEN? (DESCRIBE FULLY) DESCRIBE INJURIES RECEIVED.

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED EMPLOYEE/MEMBER FOR THESE INJURIES

NAME	ADDRESS	PHONE NUMBER
NAME	ADDRESS	PHONE NUMBER

LIST ALL WITNESSES TO ACCIDENT

NAME	ADDRESS	PHONE NUMBER
NAME	ADDRESS	PHONE NUMBER

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS OF CLAIMANT, OR AUTHORIZED REPRESENTATIVE (NO., STREET, CITY, STATE)	BUSINESS PHONE NUMBER ( )	HOME PHONE NUMBER ( )

PART D: ATTENDING PHYSICIAN'S STATEMENT

THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION OF THIS STATEMENT WITHOUT EXPENSE TO THE COMPANY.

NAME OF PATIENT	AGE	ADDRESS (STREET, CITY, STATE, ZIP CODE)

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID ACCIDENT HAPPEN? (MO., DAY, YEAR)	WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MO. DAY, YEAR)

DID THE ACCIDENTAL INJURY RESULT IN:

LOSS OF HANDS?	□ RIGHT □ LEFT	WAS SEVERANCE AT OR ABOVE WRIST JOINT?	■ YES □ NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE
LOSS OF THUMB AND FINGER OF SAME HAND?	□ RIGHT □ LEFT	WAS SEVERANCE THROUGH OR ABOVE METACARPOPHALANGEAL JOINT?	□ YES □ NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE
LOSS OF FEET?	□ RIGHT □ LEFT	WAS SEVERANCE AT OR ABOVE ANKLE JOINT?	■ YES □ NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE

TOTAL AND IRRECOVERABLE LOSS OF SIGHT OF: RIGHT EYE □ YES □ NO DATE OF LOSS_____ WAS EYE REMOVED? □ YES ■ NO DATE REMOVED_____

LEFT EYE ■ YES □ NO DATE OF LOSS_____ WAS EYE REMOVED? □ YES ■ NO DATE REMOVED_____

TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS? □ YES ■ NO DATE OF LOSS

IN YOUR OPINION, WAS ANY DISEASE, INFECTION, BODILY OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?

IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION? □ YES ■ NO

IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGHT, PLEASE ANSWER THE FOLLOWING QUESTIONS:
IF THE LOSS OF SIGHT IS PARTIAL, BUT IRRECOVERABLE, PLEASE STATE AMOUNT OF VISION IN EACH EYE WITH SNELLEN NOTATIONS, OR JAEGER SCALE IF PERTINENT.

UNCORRECTED		CORRECTED		DATE OF EXAMINATION
O.D.	O.S.	O.D.	O.S.	

DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR OPERATION? ■ YES □ NO

IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE.

WAS PATIENT CONFINED TO A HOSPITAL? ■ YES □ NO IF "YES", GIVE NAME AND ADDRESS OF HOSPITAL.

TREATMENT

DATE OF FIRST VISIT	DATES OF SUBSEQUENT VISITS			

SIGNATURE OF ATTENDING PHYSICIAN	PHYSICIAN'S NAME (PLEASE PRINT)	DEGREE	TELEPHONE ( )	DATE

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? □ YES □ NO

IF DISCHARGED, GIVE DATE OF DISCHARGE: