



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ Street City State Zip Date 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is Insured entitled to such benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Did injury or illness arise out of or in the course of occupational employment for wages or profit? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Do you recommend payment of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Inpatient <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please give names _____				
Is loss of vision irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> 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_____