blue of california

Dismemberment Claim Form for Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

Send completed form to: Blue Shield Life, 4203 Town Center Blvd., El Dorado Hills, CA, 95762, (888) 800-2742.

Note: Please complete the entire claim form. This form cannot be processed if information is incomplete. Please print using ink.

Important notice: 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 a state prison.

Statement of claimant

First name	M.I.	Last name	Telephone number ( )

Address	City	State	ZIP

Birth date (mo/day/year)	Social Security number	Age	Occupation

Date of accident	Did your accident happen on the job? ☐ Yes ☐ No	Have you been hospital confined? ☐ Yes ☐ No

Name of hospital

Address of hospital	City	State	ZIP

Date claimant entered hospital	Date released from hospital

These statements are true and complete to the best of my knowledge. I authorize any insurer, physician, or hospital to disclose any information regarding my insurance coverage or medical history. A photocopy of this form will be as valid as the original.

Signed _____ Date released from hospital _____

Statement of employer/group policyholder

Group name	Group policy number	Group effective date

Claimant's last day worked	Date claimant was employed	Claimant's insurance effective date

Basic life insurance amount $	Amount of benefit requested $	Annual salary (if benefit is salary-based) $

Is claimant's insurance still in effect? ☐ Yes ☐ No	Was claimant's insurance in effect on the day of the accident? ☐ Yes ☐ No	Is claimant still employed? ☐ Yes ☐ No

Signature

Signed _ _____ Date _____

Title	Telephone number ( )

Address	City	State	ZIP

Attending physician's statement

Name of claimant | Date of birth

Please identify the loss:

Is the loss permanent and irrecoverable?
☐ Yes ☐ No

Was the loss caused by an accident?
☐ Yes ☐ No

Diagnosis (including any complications)

Objective findings

Patient's condition
☐ Recovered ☐ Improved ☐ Retrogressed ☐ Unchanged ☐ Ambulatory ☐ Hospital confined ☐ Bed confined ☐ House confined

Date of first visit | Date of last visit

Frequency of visits
☐ Weekly ☐ Twice monthly ☐ Monthly ☐ As needed ☐ Other (specify)

When did accident happen or symptoms first appear?

Is patient able to work?
☐ Yes ☐ No

Has patient ever had the same or similar condition?
☐ Yes ☐ No If Yes, when?

Has patient been hospitalized for this condition?
☐ Yes ☐ No If Yes, when?

Name of hospital

Address of hospital | City | State | ZIP

Date patient entered hospital | Date released from hospital

Attending physician (please print)

Name | Telephone number ( )

Address of hospital | City | State | ZIP

Specialty/degree | Date

Signature

X _____