P.O. Box 7725, San Francisco, CA 94120
1-888-646-0789

DISMEMBERMENT CLAIM FORM
FOR CAREAMERICA LIFE INSURANCE COMPANY (CAREAMERICA LIFE)

NOTE: Please complete the entire claim form. This form cannot be processed if information is incomplete.

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK 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

FULL NAME			TELEPHONE NO. ( )
ADDRESS (NUMBER, STREET, APARTMENT)	CITY	STATE	ZIP
BIRTHDATE (mo/day/yr)	SOCIAL SECURITY NO.	AGE	OCCUPATION
DATE OF ACCIDENT	DID YOUR ACCIDENT HAPPEN "ON THE JOB?" ☐ Yes ☐ No	HAVE YOU BEEN HOSPITAL CONFINED? ☐ Yes ☐ No	
NAME OF HOSPITAL			
STREET 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: X ______________________________ DATED ______________________, 20________

STATEMENT OF EMPLOYER/GROUP POLICYHOLDER

GROUP NAME		
GROUP POLICY NO.		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: X ______________________________ DATED ______________________, 20________

TITLE			TELEPHONE NO.
STREET ADDRESS	CITY	STATE	ZIP

ATTENDING PHYSICIAN'S STATEMENT

NAME OF CLAIMANT	DATE OF BIRTH

PLEASE IDENTIFY THE LOSS:

____

____

____ ICD CODE (if known) ______________

IS THE LOSS PERMANENT AND IRRECOVERABLE?	WAS THE LOSS CAUSED BY AN ACCIDENT?
☐ Yes ☐ No	☐ 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	CITY	STATE	ZIP

DATE PATIENT ENTERED THE HOSPITAL

DATE RELEASED FROM HOSPITAL

ATTENDING PHYSICIAN (please print)

NAME	TELEPHONE NO. ( )

ADDRESS	CITY	STATE	ZIP

SPECIALTY/DEGREE	DATE

SIGNATURE

X ______________________________

THANK YOU FOR YOUR ASSISTANCE.