

**Great Lakes  
Employers  
Association**



**Group Marketing Services, Inc.**

Group Insurance That *Benefits Small Business*

**Physician Statement  
Group Life Insurance Claim Form**

Please send completed form and all attachments to:  
P.O. Box 19040  
Kalamazoo, MI 49019-0040

**To avoid unnecessary delays, be sure all parts of the  
Claim Form are completed according to the instructions.**

**TO BE COMPLETED BY ATTENDING PHYSICIAN**  
(Must be completed and signed by your physician)

1. Name of Patient - (please print) Last, First M.I.		2. As a result of this accident, the patient suffer a loss of: (Give anatomical location of amputation and date performed)	
3. Date of accident		<input type="checkbox"/> Left hand: <input type="checkbox"/> Right hand: <input type="checkbox"/> Left foot: <input type="checkbox"/> Right foot:	
4. Date patient first consulted you for injuries resulting from this accident		<input type="checkbox"/> Sight of right eye, estimated % loss: <input type="checkbox"/> Sight of left eye, estimated % loss: Is loss of sight total and irrecoverable? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", date loss of sight became total and irrecoverable:  Give details if sight can be restored to either eye:	
5. Diagnosis and concurrent conditions			
6. Is patient still under your care for this condition? <input type="checkbox"/> No <input type="checkbox"/> Yes			
7. Was loss due solely to this accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If "No", give details of any contributory causes:			

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Physician's Name: \_\_\_\_\_ Degree/Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's EIN/SSN/NPI: \_\_\_\_\_