Assurity Life Insurance Company
P.O. Box 19040 ▪ Kalamazoo, MI 49019-0040 ▪ Phone: 269-343-2611 ▪ Fax: 269-349-3275 ▪ www.groupmarketingservices.com

Group Dismemberment Claim Form - Insured Statement

To avoid unnecessary delays, be sure all parts of the Claim Form are completed accordingly.

PART I - TO BE COMPLETED BY EMPLOYEE

1. Full name of Insured – *Last, First, M.I. (please print)*

3. Full address *(street, city, state)*

4. Social security number	5. Date of birth	6. Last day worked

8. Occupation	9. Phone number

11. Work classification ☐Hourly ☐Salary ☐Commission Only	12. Date of accident

13. Time of accident ☐am ☐pm	14. Did the accident happen at work? ☐No ☐Yes; *attach copy of accident report*

7. Date physician first treated you due to this injury:

2. Physicians consulted because of these injuries

Name(s)	*Address*

10. Describe in detail how and where the accident happened.
(Attach newspaper clipping, police or accident reports if available)

15. If not actively at work immediately prior to injury, what was the reason? ☐Disability ☐Leave of Absence ☐Resigned ☐Discharged ☐Vacation ☐Temporary Layoff ☐Retired ☐Other:______________________

16. Employer name

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading Information may be guilty of a criminal act punishable under law. I hereby agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is In excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

Employee Signature:____Date: __________________________

AUTHORIZATION

I, on behalf of myself or the person named above ("Claimant"), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau ("MIB"), consumer reporting agency, employer, Social Security Administration, Internal Revenue Service, Veterans Administration or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"); its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (except as maybe related directly or indirectly to sexual orientation), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of Human Immuno deficiency Virus (HIV) infection and sexually transmitted diseases.
- Information on the diagnosis & treatment of mental illness & the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

I understand this information maybe released by the Company and/or its reinsurers to their consulting physicians, attorneys, MIB, and to other insurance companies in which the Claimant has policies or to whom claims for benefits have been made or maybe submitted. By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Claimant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose the Claimant's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it maybe subject to re-disclosure and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by providing written notice to the Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Claimant to obtain treatment. I further understand that if I refuse to sign this authorization, Company may not be able to make any benefit payments.

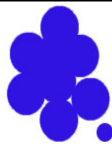
I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

____ ____________________

Signature of Insured or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Insured:_________________________________

Great Lakes Employers Association



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.*

3. Date of accident

4. Date patient first consulted you for Injuries resulting from this accident

5. Diagnosis and concurrent conditions

6. Is patient still under your care for this condition? ☐No ☐Yes

7. Was loss due solely to this accident? ☐No ☐Yes
If "No", give details of any contributory causes:

2. As a result of this accident, the patient suffer a loss of:
(Give anatomical location of amputation and date performed)

☐ Left hand:
☐ Right hand:
☐ Left foot:
☐ Right foot:

☐ Sight of right eye, estimated % loss:
☐ Sight of left eye, estimated % loss:
Is loss of sight total and irrecoverable? ☐No ☐Yes
If "Yes", date loss of sight became total and irrecoverable:

Give details if sight can be restored to either eye:

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:________________

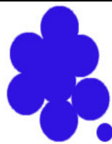
Address:____

Telephone Number:____________________ Fax Number:______________________

Signature:________________________________ Date:__________________

Physician's EIN/SSN/NPI:____________________

Great Lakes Employers Association



Employer Statement
Group Dismemberment Claim Form

Please send completed form and all attachments to:

P.O. Box 19040
Kalamazoo, MI 49019-0040

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PART III - TO BE COMPLETED BY EMPLOYER

1. Full name of Insured - *(please print)* *Last, First M.I.*

2. Full time hire date

3. Work classification ☐Hourly ☐Salary ☐Commission Only

4. Last day worked

6. Reason for not working after this date

7. Base salary $ per

8. Work Schedule ☐Full Time ☐Part Time ☐Seasonal ☐Contracted ☐Board Member

9. Hours worked per week

7. If not actively at work immediately prior to injury, what was the reason? ☐Disability ☐Leave of Absence ☐Resigned ☐Discharged ☐Vacation ☐Temporary Layoff ☐Retired ☐Other:____________________

8. Was insurance in force when injuries were sustained? ☐Yes ☐No; If “No” give date and reason for termination

8. Occupation

14. Did the accident happen at work? ☐No ☐Yes; *explain & attach copy of accident report*

16. Employer name

17. Employer address – *Street* *City* *State* *Zip*

18. Location name and address where employed *Location Name* *Street* *City* *State* *Zip*

19. Do you have any additional information relating to this claim?

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading Information may be guilty of a criminal act punishable under law.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

23. Signature

Employer contact name:____________________ Date:____________________

Signature:____________________ Title:____________________