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.*

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:_____