ZURICH

DISMEMBERMENT CLAIM FORM

NAME OF EMPLOYERS:	ADDRESS OF EMPLOYER:	POLICY NO.:
NAME OF CLAIMANT:	ADDRESS OF CLAIMANT:	CERTIFICATE NUMBER:
TELEPHONE NUMBER:	DATE OF BIRTH:	DATE EMPLOYED:

EFFECTIVE DATE OF COVERAGE:	DATE OF LAST PREMIUM PAYMENT:	BASE SALARY:	WEEKLY SALARY:	MONTHLY SALARY:

OCCUPATION: (DESCRIBE DUTIES)

IS THERE A CLAIM UNDER COMPENSATION ACT? ☐ YES ☐ NO	NAME OF CARRIER:	DATE LAST WORKED: ☐A.M. ☐P.M.	HAS EMPLOYEE RETURNED TO WORK: ☐ YES ☐ NO (IF YES, GIVE DATE)

COMPLETED BY:	TITLE:	DATE:

TO BE COMPLETED BY CLAIMANT

DATE ACCIDENT OCCURRED OR SICKNESS BEGAN:	NATURE OF INJURY OR SICKNESS:

IF ACCIDENT – DESCRIBE HOW AND WHERE OCCURRED:

IF SICKNESS – DATE SYMPTOMS FIRST NOTICED:	HAD THIS SICKNESS CAUSED YOU PREVIOUS TROUBLE? ☐ YES ☐ NO (IF YES, WHEN?)

NAME OF ATTENDING PHYSICIAN:	ADDRESS:	DATE FIRST TREATED:

OTHER PHYSICIANS CONSULTED: (NAME AND ADDRESS)

HAVE YOU BEEN CONFINED TO A HOSPITAL? ☐ YES ☐ NO (IF YES, NAME AND ADDRESS)

DATE ADMITTED TO HOSPITAL:	DISCHARGED:	WHEN DO YOU EXPECT TO RESUME LIGHT WORK:	WHEN DO YOU EXPECT TO RESUME USUAL DUTIES:

OTHER INSURANCE (LIFE, ACCIDENT, DISABILITY, HOSPITAL OR MEDICAL EXPENSE: (STATE NAMES OF COMPANIES OR ASSOCIATIONS AND AMOUNT IN EACH.)

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PERSON TO FURNISH ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL OR MEDICAL RECORDS REGARDING _____ _____ (CLAIMANT).

I HEREBY AUTHORIZE ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE TO RELEASE THE INFORMATION DESCRIBED ABOVE TO ANY EXPERT, INVESTIGATOR, PHYSICIAN, MEDICAL PRACTICIONER, HOSPITAL, MEDICAL OR MEDICAL RELATED FACILITY, INSURANCE COMPANY, REINSURER, PLAN ADMINISTRATOR, PLAN SPONSOR OR EMPLOYER FOR THE PURPOSE OF INVESTIGATING AND/OR ADJUDICATING MY CLAIM. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE OF CLAIMANT: _____ DATE _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

NAME OF PATIENT:	**AGE:**
NATURE OF SICKNESS OR INJURY: (DESCRIBE COMPLICATIONS, IF ANY)	
DATE ACCIDENT OCCURRED OR SYMPTOMS APPEARED:	DATE PATIENT CONSULTED YOU FOR THIS CONDITION:
HAS PATIENT EVER HAD SIMILAR CONDITION? ☐ YES ☐ NO (IF YES, WHEN, DESCRIBE)	
DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION:	
NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE : (DESCRIBE FULLY)	CHARGE: $ DATE PERFORMED:
DATES OF TREATMENT: OFFICE: HOME: HOSPITAL:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO (IF DISCHARGED, GIVE DATE)
IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL:	DATE ADMITTED: DATE DISCHARGED:
HOW LONG AS OR WILL PATIENT BE TOTALLY DISABLED? (UNABLE TO WORK) FROM: THROUGH:	HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? FROM: THROUGH:
IF SICKNESS, WAS PATIENT, CONFINED TO HOUSE: ☐ YES ☐ NO (IF YES, GIVE DATES) FROM: THROUGH:	
REMARKS:	

SIGNATURE OF DOCTOR: _____ DATE: _____

TO BE COMPLETED ONLY FOR LIMB AMPUTATIONS BY ATTENDING PHYSICIAN

1. Which limbs were severed or amputated?
   _____
   _____
2. State the dates on which the severance or amputation occurred._____
3. State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost.
   _____
   _____
4. State the cause of the amputations._____
5. Did the patient ever consult you before? If so please state the dates and the ailments for which you attended, treated, or examined._____
   _____
   _____
   _____
6. Please give the names of other physicians who have attended this patient, and the dates of their first and last treatments as reported to you._____
   _____
7. Was the injury described solely responsible for the loss._____
8. If not, give the particulars of any contributing cause or causes
   _____
   _____
   _____

TO BE COMPLETED ONLY FOR LOSS OF VISION BY ATTENDING PHYSICIAN

1. Give the dates you first determined vision was irrecoverably reduced to 20/200 or less with correction and the vision then remaining in each eye.

   Date:

   O.D.V. Uncorrected_____ Corrected
   O.S.V. Uncorrected_____ Corrected

2. Give the dates and vision found on last eye examination.

   Date:

   O.D.S. Uncorrected_____ Corrected
   O.S.V. Uncorrected_____ Corrected

3. State the cause of the loss of vision:

4. Indicate whether recovery or useful vision is possible by operation or treatment.

   O.D. Operation Treatment
   O.S. Operation Treatment

Signed_____
Attending Physician
Address_____Phone Number_____
_____