CM Regent Solutions
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NOTICE OF CLAIM PROOF OF EMPLOYEE'S ACCIDENTAL DISMEMBERMENT

Type(s) of Accidental Dismemberment Claim: ☐ Loss of Limb ☐ Loss of Vision ☐ Loss of Hearing ☐ Loss of Speech ☐ Quadriplegia ☐ Paraplegia ☐ Hemiplegia

Employer's Statement

Name of Employee (First, Middle, Last)	Maiden Name	Other Names by which Employee is known as	Group Account Number

Legal Residence at Time of Death (No., Street, City, State and Zip Code)	Date of Birth	Date of Death

Date First Entered Employment	Effective Date of Coverage	Amount of Acc. Dis. Insurance Basic	Supplemental	Voluntary

Number of Hours Worked Each Week	Occupation	Date Last Worked on a Full-time Basis	Date Premium Payments Ceased	Date of Last Salary Change

Basic Annual Earnings as of Date Last Worked	Employment Status
	☐ Still Actually Working ☐ Retired ☐ Totally Disabled ☐ Sick Leave ☐ Temporary Layoff ☐ No Longer Employed

PLEASE COMPLETE ALL ABOVE ITEMS BEFORE SIGNING. It is certified that the statements contained above are true to the best of our knowledge and belief.

Signature of Authorized Personnel	Print Name	Title	Date Signed

Name of Employer	Telephone Number

Address (No., Street, City, State and Zip Code)	Fax Number

Employee's Statement

Date of Accident	Place of Accident	Describe How Accident Occurred

Date of Birth	Social Security Number	Gender ☐ Male ☐ Female	Date Last Worked	Date You Expect to Be Able to Work

Address (No., Street, City, State and Zip Code)

I authorize the release and disclosure of my protected health information and other information as described below.

My **protected health information** is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any health care provider, health care facility, the Medical Information Bureau or similar organization, insurance or reinsurance company, to disclose or furnish to **Sun Life and Health Insurance Company (SLHIC (U.S.))** and its legal representatives, the following protected health information: **Medical records or other information of a medical nature in regard to my physical or mental condition or the physical or mental condition of my dependents.** This authorization extends to and includes HIV-related information, AIDS or AIDS related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law. I further authorize any employer, group policyholder or benefits plan administrator to disclose or furnish my employment, financial and wage information to SLHIC (U.S.) and its legal representatives.

I authorize SLHIC (U.S.) to use or disclose this protected health information to any reinsurer and to any person or entity performing a business or legal function on behalf of SLHIC (U.S.) or as otherwise specifically permitted or required by law.

I understand that: (1) the protected health information being released will be used for the purpose of evaluating a claim for insurance benefits; (2) my refusal to sign this authorization may adversely affect a claim; (3) I have the right to revoke this authorization at any time by writing to SLHIC (U.S.) at the address listed at the top of this form; and (4) I am entitled to a photocopy of this authorization upon request.

This authorization is valid for up to 24 months from the date it was signed. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. A photocopy of this authorization shall be as valid as the original.

Signature of Employee	Telephone Number	Date Signed

Certificate of Attending Physician - To be furnished without expense to Sun Life and Health Insurance Company (U.S.).

Name of Patient (Last, First, M.I.) - Please Print	Name of Attending Physician (PLEASE PRINT)	Telephone Number
Address (No., Street)	Address (No., Street)	
(City, State, ZIP Code)	(City, State, ZIP Code)	

Accidental Dismemberment Claims

Date of Loss	Was loss due to accidental means? ☐ Yes ☐ No	Date Injury Occurred

Describe How Loss Occurred

Diagnosis

Loss of Limb - What was the anatomical level of amputation?

Loss of Sight - Is the patient totally blind? ☐ Yes ☐ No
If no, what was vision at last observation?

Can vision be improved by treatment, operation or lenses? ☐ Yes ☐ No

Has all practical use of vision been lost in the injured eye? ☐ Yes ☐ No

Remarks

Loss of Hearing - Is the patient totally deaf? ☐ Yes ☐ No
If no, what was hearing at last observation?

Can hearing be improved by treatment, operation or hearing aid or device? ☐ Yes ☐ No

Loss of Speech - Has the patient suffered an entire loss of speech? ☐ Yes ☐ No
Can speech be regained through treatment, operation or device? ☐ Yes ☐ No

Paralysis - Is the loss of movement complete and permanent? ☐ Yes ☐ No
Can movement be regained through treatment or operation? ☐ Yes ☐ No

TREATMENT	Date of First Visit	Date of Last Visit	Date Insured Was Obliged to Cease Work	Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other

If employee is disabled and unable to work, please also answer the following questions so we may review a claim for Extended Life Insurance Waiver of Premium Benefits:

PROGRESS

The patient is:
☐ Recovered ☐ Unimproved
☐ Improved ☐ Retrogressed

The patient is:
☐ Ambulatory ☐ House Confined
☐ Bed Confined ☐ Hospital Confined

PHYSICAL IMPAIRMENT

☐ Class 1 - No limitation of functional capacity, capable of heavy work*. No restrictions (0-10%)
☐ Class 2 - Medium manual activity*. (15-30%)
☐ Class 3 - Slight limitation of functional capacity, capable of light work*. (35-55%)
☐ Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary*) activity. (60-70%)
☐ Class 5 - Severe limitation of functional capacity, incapable of minimum (sedentary*) activity. (75-100%)
*As defined in Federal Dictionary of Occupational Titles.

MENTAL/ NERVOUS IMPAIRMENT (if applicable)

☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has significant loss of psychological, personal and social adjustment (severe limitations)
☐ Is Patient competent to change his/her beneficiary? ☐ Yes ☐ No

CARDIAC

Functional Capacity (American Heart Association)
☐ Class 1 - No limitation ☐ Class 2 - Slight limitation ☐ Class 3 - Marked limitation ☐ Class 4 - Complete limitation

DEGREE OF DISABILITY

(a) Is patient unable to perform the duties of any occupation? ☐ Yes ☐ No

(b) What duties of patient's job is he/she incapable of performing?

(c) Do you expect an improvement in the future? (If "yes", when will patient recover sufficiently to perform any work duties?)
☐ Yes ☐ No

REHABILITATION

Is patient a suitable candidate for future rehabilitation services? (i.e., Cardiopulmonary program, speech therapy, work-hardening, etc.)
☐ Yes ☐ No

Can present job be modified to allow for handling with impairment?
☐ Yes ☐ No

When could trial employment commence? (Month/Day/Year)
/ / ☐ Full-Time ☐ Part-Time

Would vocational counseling and/or retraining be recommended?
☐ Yes ☐ No

Attending Physician's Signature	Date Signed

General fraud warning: 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 purpose 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.

AK: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, MA, MN, TX and WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: 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 state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DC: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DE, ID and IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

KS: 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 purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MD: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR: Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TN and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.