SHELTERPOINT
Claim Form

ShelterPoint Life Insurance Company
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Accidental Death & Dismemberment

All pages must be completed for claim processing

A. General Information (Employer completes)

1. Employer (Business Name)			Policy#
Business Address			
	City	State	ZIP
	Name of Authorized Representative	Title	
	Phone	Contact E-mail	
2. Deceased/injured Employee (Last, First, Middle Initial)			
	Address		
	City	State	ZIP
	Phone	Occupation	
Date hired	Date last worked	Date returned to work (if applicable)	
Date of Birth (mm/dd/yyyy)	Social Security #		

Signature of Employer's Authorized Representative	Date

B. Accident Circumstances (Employee completes; Employer completes in event of death)

Did this accident happen on the job or did it arise out of/in the course of the deceased's/injured's employment? ☐ yes ☐ no
Has this claim been considered in connection with a Workers' Compensation Claim? ☐ yes ☐ no
If yes, what is the status of the claim?

Date/Time of Accident	Place of Accident (Location, City/State)
Describe all injuries received:	Describe in detail how the accident happened:

Name and address of law enforcement agency involved ***(Please submit copy of Police Report and/or Case#)***

List name/address/phone# of all physicians consulted on this death/injury

List name/address/phone# of all hospitals consulted on this death/injury

Did/does the deceased/injured have any chronic disease or physical defect/deformity? ☐ yes ☐ no If yes, describe in detail:	
Did the accident result in death? ☐ yes ☐ no	If yes, on what date? _____ Was deceased an active, eligible employee at time of death? ☐ yes ☐ no Was autopsy performed? ☐ yes ☐ no If yes, provide name/address/phone# of coroner or copy of autopsy report:_____ Was an inquest held? ☐ yes ☐ no If yes, verdict:
	Beneficiary: AD&D death benefits under the DBL Rider are payable to estate of the deceased. All other benefits are paid to the injured employee.

<u>NOTICE</u>: 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

In what capacity are you making the claim? _____
If other than injured employee (or employer's authorized representative in case of death), attach appropriate legal documents.
Your relationship to injured employee: _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the deceased or injured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV, and alcohol/drug records to release all such records in their entirety to ShelterPoint Life Insurance Company and any affiliate (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, other insurance company or Workers' Compensation carrier.

Signature of injured Employee Date	Signature of Employer's Authorized Representative (in case of death) Date
Signature of other Representative Date	

C. Attending Physician's Statement (Physician completes)

Patient's Name	Date of Birth	Social Security#

Address		
City	State	ZIP

Date of Injury	Date of first Visit	Date of last Visit	Frequency ☐ weekly ☐ monthly ☐ other _____

Had patient previously had medical attention for this injury? ☐ yes ☐ no
If yes, prescribed by whom?

Objective Findings (EKGs, x-rays, lab data, clinical findings)	Diagnosis

Symptoms	What complications have arisen, if any?

Was the injury solely responsible for the loss? ☐ yes ☐ no
If no, give particulars of any contributing cause(s):

Was patient under the influence of alcohol and/or other prescription or non-prescription drugs or other substances at the time of accident/injury? ☐ yes ☐ no ☐ unknown

Is condition due to injury/sickness arising out of patient's employment? ☐ yes ☐ no ☐ unknown

Nature of Treatment (type of surgery, medications)	Date of Surgery

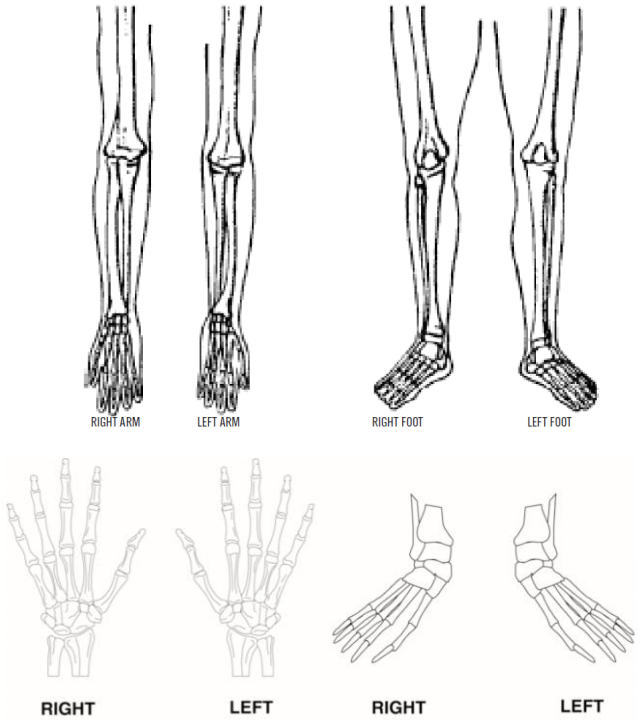
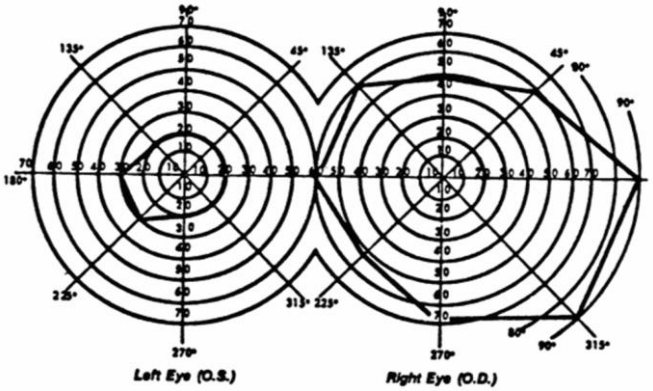
Has patient been hospital-confined? ☐ yes ☐ no If yes, name and address of Hospital	Hospital Stay from _____ through _____

Name of Surgeon

List name/address/phone# of all other treating physicians

Patient's Condition: ☐ recovered ☐ improved ☐ unchanged ☐ retrogressed

Patient is: ☐ ambulatory ☐ bed confined ☐ house confined ☐ hospital confined ☐ hospice care

Complete for Injury/Loss of Limb(s)	Complete for Loss of Vision
Please indicate on illustration below: ☐ area of injury or ☐ location of amputation	Did the injury necessitate removal of either or both eyes? ☐ yes ☐ no If yes, ☐ right ☐ left eye, date of removal:
	First eye exam and visual acuity (using Snellen Notation): Date ____ Uncorrected ____ Corrected O.D. ____ O.S. ____ Last eye exam and visual acuity (using Snellen Notation): Date ____ Uncorrected ____ Corrected O.D. ____ O.S. ____ If fields of vision are contracted, show contraction below: 
Comments/Description:	Vision can be restored in whole or part by: ☐ lenses ☐ treatment ☐ operation ☐ O.D. ☐ O.S. ☐ not restorable If operation, do you recommend it? ☐ yes ☐ no
If amputation was necessary: Was the injury, of itself and independent of all other causes, sufficient to require amputation? ☐ yes ☐ no	Date corrected vision was irrevocably reduced to 20/200 or less:
Please attach copies of office notes related to this incident.	

Physician Name (please print)			
Address			
City		State	ZIP
Phone	E-mail	Tax ID	
Physician's Specialty/Degree			
Physician's Signature		Date	