ESIS®

Accidental Dismemberment Claim Form

Please mail your completed Claim Form along with the items listed below to:

ESIS Specialty Claims
PO Box 6802
Scranton, PA 18505-0556

(844) 756 5571 Inside USA
(248) 368 0577 Outside USA
(248) 440 7626 Fax
ESISA&H@esis.com

Policyholder Name: ______________________ Policy Number(s): ______________

Facts concerning insured

First Name: ______________________ Last Name: ______________________

SSN: ______________________

Email Address: ______________________ Cell Number: ______________

Home Address: ______________________

Address Line2: ______________________

City: ______________________ State: ______________

ZIP: ______________ Country: ______________________

County: ______________________

Date of Birth (DD/MM/YYYY) ______________ Place of Birth: ______________

Gender: ☐ Male ☐ Female

Employer Information for Policyholder/Insured

Name of Employer: ______________________

Occupation: ______________________ Annual Salary: $ ______________

Street Address: ______________________

Address Line2: ______________________

City: ______________________ State: ______________

ZIP: ______________ Country: ______________________

Describe duties: ______________________

____

Accident Information

When did the accident happen (DD/MM/YYYY): ______________________

Incident Address: ______________________

Address Line2: ______________________

City: ______________________ State: ______________

ZIP ______________ Country: ______________________

How did it happen? ______________________________

____

What were you doing at the time? ______________________________

What injury did you sustain? ______________________________

Provide Information for any Physician, Specialist, or Hospital Visited

Name of Hospital/Specialist/Physician 1:

____

Street Address: ______________________________

Address Line2: ______________________________

City: State: ______________

ZIP: ______________ Country: ______________

Name of Attending Physician: ______________________________

Phone Number: ______________ Fax Number: ______________

What Operation/Treatment was Performed: ______________________________

Treatment From (DD/MM/YYYY): __________ Treatment Through (DD/MM/YYYY): __________

Name of Hospital/Specialist/Physician 2:

____

Street Address: ______________________________

Address Line2: ______________________________

City: ______________ State: ______________

ZIP: ______________ Country: ______________

Name of Attending Physician: ______________________________

Phone Number: ______________ Fax Number: ______________

What Operation/Treatment was Performed: ______________________________

Treatment From (DD/MM/YYYY): __________ Treatment Through (DD/MM/YYYY): __________

Name of Hospital/Specialist/Physician 3:

____

Street Address: ______________________________

Address Line2: ______________________________

City: ______________ State: ______________

ZIP: ______________ Country: ______________

Name of Attending Physician: ______________________________

Phone Number: ______________ Fax Number: ______________

What Operation/Treatment was Performed: ______________________________

Treatment From (DD/MM/YYYY): __________ Treatment Through (DD/MM/YYYY): __________

Witness Information

Were there witnesses to the accident? ☐ Yes ☐ No

If **Yes**, please provide the following details:

Witness 1

First Name: ______________ Last Name: ______________

Phone Number: ______________

Street Address: ______________

Address Line2: ______________

City: ______________ State: ______________

ZIP: ______________ Country: ______________

Home Phone: ______________ Cell Phone: ______________

Witness 2

First Name: ______________ Last Name: ______________

Phone Number: ______________

Street Address: ______________

Address Line2: ______________

City: ______________ State: ______________

ZIP: ______________ Country: ______________

Home Phone: ______________ Cell Phone: ______________

Witness 3

First Name: ______________ Last Name: ______________

Phone Number: ______________

Street Address: ______________

Address Line2: ______________

City: ______________ State: ______________

ZIP: ______________ Country: ______________

Home Phone: ______________ Cell Phone: ______________

Employer's or Adminstrator's Statement

Group Policy Number: ______________

Certificate Number (if applicable): ______________

Policyholder First Name: ______________ Last Name: ______________

Occupation: ______________ Annual Salary: $ ______________

Amount of Insurance: ______________

Individual Coverage Effective Date (DD/MM/YYYY): ______________

Length of Employment From (DD/MM/YYYY): ______________ To (DD/MM/YYYY): ______________

Individual Coverage Expiration (if applicable) (DD/MM/YYYY): ______________

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Name of Employer: ______________________________

Street Address: ______________________________

Address Line2: ______________________________

City: ______________________________ State: ______________________________

ZIP: ______________ Country: ______________________________

Date of Accident (DD/MM/YYYY): ___________ Last Date at Work (DD/MM/YYYY): ______________

Authorization and Assignment of Benefits

I ____________________ *authorize* any physician, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to______________________________, deceased, to give us or our legal representative any and all such information for the purpose of evaluating a claim for benefits.

I *understand* the information obtained by use of this authorization will be used by ESIS to determine eligibility for benefits under the policy insuring said deceased. Any information obtained will not be released by us to any person or organization except to reinsuring companies, policyholders or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, permitted or as I may further authorize.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.

I *agree* this Authorization shall be valid for two years from the date shown below.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

____

Signature of Insured or Authorized Representative

____

Signature of Parent / Legal Guardian of Authorized Representafive of Claimant, if Claimant if a minor)

Date: ______________________________

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Attending Physican's Statement

Patient's First Name: Last Name:

Date of Birth (MM/DD/YYYY):

Patient Address: ____________________

Address Line2: ____________________

City: ____________________ State: ____________________

ZIP: ____________ Country: ____________________

Diagnosis:

If loss is sight, is loss in both eyes? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, vision acuity at this time: ____________________

If loss is hearing, is loss in both ears? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, hearing at this time: ____________________

If loss is speech, is loss total and irreversible: ☐ Yes ☐ No

If no, speech at this time: ____________________

If loss is extremity, where is severance? ____________________

In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

In your opinion, was the loss caused in any way by illness? ☐ Yes ☐ No

If **Yes**, list dates you provided treatment for this illness: ____________________

____

Please give an account of the accident as you understand it happened: ____________________

____

____

____

Dates of treatment for this accident: ____________________

____

To your knowledge, has the patient ever been treated for this same condition? ☐ Yes ☐ No

If **Yes**, please explain: ____________________

____

____

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Remarks: ____

____

____

____

Name of Attending Physician (Please print) ______________________________

Street Address: ____

Address Line2: ____

City: ______________________ State: ______________________

ZIP: ______________ Country: ______________________

Signature of Authorized Representative: ______________________________

Date: ____

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic Warning:
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents 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.
Colorado
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.
Florida
Any person who knowingly and with intent in 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.
New York
Any person who knowingly and with 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 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.
Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania:
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 and subjects such person to criminal and civil penalties.
Maryland/Oregon
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 be guilty of insurance fraud.
Virginia
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.