



# Claim for Accidental Means Dismemberment Benefits Federal Employees' Group Life Insurance Program

## Instructions to Claimant

**1. General -**

To avoid delay:

- (a) Read these instructions carefully.
- (b) Type or print in ink.

**2. Completion of claim -**

Part A should be completed by the claimant (usually the insured employee). The claimant should then have Part C on the reverse side completed by the attending physician.

**3. Medical and accident reports -**

Please attach copies of all medical reports from the first

date until the last date of treatment received as a result of the accident. Any police/traffic accident or other accident related reports should be attached.

**4. If assistance is needed -**

If you need assistance in completing this claim contact the employing office of the department or agency in which you are employed.

**5. Where to send claim -**

Forward the completed claim to the employing office of the department or agency in which you are employed.

Part A - General Information Concerning the Insured		
1. Full name of the insured ( <i>Last, first, middle</i> )	2. Date of birth ( <i>Month, day, year</i> )	3. Social Security Number
4. Department or agency in which employed, including bureau or division	5. Location of employment (City, State & Zip Code)	6. When did the accident happen? (Month, day, year)
		7. Where did the accident happen? (City and State)
8. Give a brief description of the accident (Attach all medical and accident reports as instructed above)		
I hereby certify that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld. I also authorize the physician to release any information requested with respect to this claim.		
Signature of claimant		Address
Telephone number (day) (evening)	Date	

## Instructions to Employing Agency

It is the agency's responsibility to assist the claimant in properly completing this claim. After Parts A and C have been completed, the agency should fully complete Part B and forward the claim to:

**Office of Federal Employees' Group Life Insurance  
200 Park Avenue  
New York, NY 10166-0188**

Part B - Certification of Insurance Status		
1. Annual rate of basic pay established for basic life insurance purposes on the date of the accident.	→	\$
2. Was employee covered by Option A - Standard life insurance on the date of the accident? YES <input type="checkbox"/> NO <input type="checkbox"/>	→	Date of election
I certify that the above information has been obtained from and correctly reflects official records and the employee named was covered by Federal Employees' Group Life Insurance on the date of the accident.		
Signature of authorized agency official	Name of agency	
Name of authorized agency official (type or print)	Mailing address of agency, including ZIP Code	
Title		
Date	Commercial telephone number ( ) Area code	Fax number ( ) Area code

**Part C - Physician's Statement**

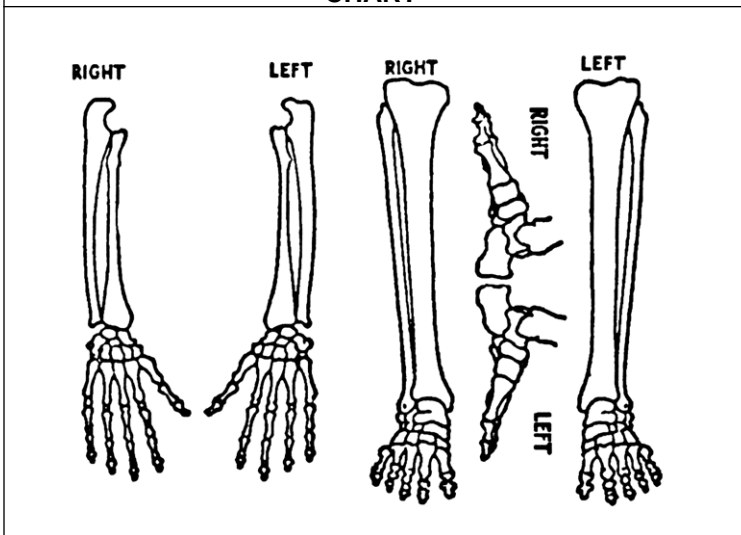
1a. Name of patient		1b. Age
2a. Date of accident ( <i>month, day, year</i> )	2b. Date first consulted on account of injury described ( <i>month, day, year</i> )	2c. Date of last treatment ( <i>month, day, year</i> )

3. Describe the exact nature, location, and extent of all injuries sustained. (Attach all medical reports relevant to the treatment of the injury incurred)

4. Was the injury described solely responsible for the loss?  YES  NO → Give the particulars of any cause or causes, including disease, which contributed to the loss.

<b>To Be Completed Only for Limb Amputations</b>	<b>To Be Completed Only for Loss of Vision</b>												
5a. Which limbs were severed or amputated?	5a. Give the date of exam and vision prior to the accident. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td align="center" colspan="2">Uncorrected</td> <td align="center">Corrected</td> </tr> <tr> <td>(Snellen Notations)</td> <td>Right eye</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Left eye</td> <td></td> <td></td> </tr> </table>		Uncorrected		Corrected	(Snellen Notations)	Right eye				Left eye		
	Uncorrected		Corrected										
(Snellen Notations)	Right eye												
	Left eye												
5b. On what dates did the severances or amputations occur?	5b. State the loss of vision.												
5c. State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.	5c. Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td align="center" colspan="2">Uncorrected</td> <td align="center">Corrected</td> </tr> <tr> <td>(Snellen Notations)</td> <td>Right eye</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Left eye</td> <td></td> <td></td> </tr> </table>		Uncorrected		Corrected	(Snellen Notations)	Right eye				Left eye		
	Uncorrected		Corrected										
(Snellen Notations)	Right eye												
	Left eye												
5d. State the causes of the amputations.	5d. Give the date and vision found on last eye examination. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td align="center" colspan="2">Uncorrected</td> <td align="center">Corrected</td> </tr> <tr> <td>(Snellen Notations)</td> <td>Right eye</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Left eye</td> <td></td> <td></td> </tr> </table>		Uncorrected		Corrected	(Snellen Notations)	Right eye				Left eye		
	Uncorrected		Corrected										
(Snellen Notations)	Right eye												
	Left eye												
6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated, or examined the patient.	6. Indicate whether recovery of useful vision is possible by operation or treatment. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Right eye</td> <td>Operation</td> <td><input type="checkbox"/></td> <td>Treatment</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Left eye</td> <td>Operation</td> <td><input type="checkbox"/></td> <td>Treatment</td> <td><input type="checkbox"/></td> </tr> </table>	Right eye	Operation	<input type="checkbox"/>	Treatment	<input type="checkbox"/>	Left eye	Operation	<input type="checkbox"/>	Treatment	<input type="checkbox"/>		
Right eye	Operation	<input type="checkbox"/>	Treatment	<input type="checkbox"/>									
Left eye	Operation	<input type="checkbox"/>	Treatment	<input type="checkbox"/>									

**CHART**



7. If eye is enucleated, give date.

8. If fields of vision are contracted, show contraction on chart below.

Left Eye <b>L.E.</b>	Right Eye <b>R.E.</b>
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<b>I hereby certify that all statements made above are true to the best of my knowledge and belief.</b>		Office Address - Number and Street	
Signature of Physician	Date	City, State and ZIP Code	
		Telephone number ( ) Area code	Fax number ( ) Area code