Gerber Life Insurance Company

Dismemberment / Loss of Use Claim Form

Please complete and return to:
A C Newman & Co.
7060 N. Marks Ave., Suite 108
Fresno, CA 93711
(559) 252-2525

EMPLOYER'S STATEMENT - TO BE COMPLETED BY EMPLOYER (Policyholder)

Type of Claim ☐ **Dismemberment** ☐ **Loss of Use** ☐ **Paralysis** **Other** _____

FULL NAME OF INJURED		HOME ADDRESS OF INJURED	
THE CLAIM IS FOR: (Check One) ☐ Employee ☐ Dep. Spouse ☐ Dep. Child	Gender ☐ Male ☐ Female	DATE OF BIRTH	INJURED SOCIAL SECURITY NUMBER
NAME OF CLAIMANT	Gender ☐ Male ☐ Female	CLAIMANT PHONE NUMBER	CLAIMANT EMAIL ADDRESS
ADDRESS OF CLAIMANT			

NAME OF EMPLOYER	ADDRESS OF EMPLOYER
NAME AND ADDRESS OF DIVISION WHERE EMPLOYEE WORKED (IF DIFFERENT FROM ABOVE)	

POLICY NUMBER(S)	CLASS	DATE OF LAST PAYROLL DEDUCTION / LAST PREMIUM PAYMENT	CLAIM AMOUNT
_____	_____	_____	$ _____
_____	_____	_____	$ _____
_____	_____	_____	$ _____

For Business Travel Accident Claims: If loss occurred while on business travel, please attach an additional page describing the circumstances of the business trip including purpose and location(s).

NAME OF EMPLOYEE		HOME ADDRESS OF EMPLOYEE	
DATE HIRED	DATE LAST WORKED	JOB POSITION/TITLE	EFFECTIVE DATE OF EMPLOYEE COVERAGE
BASE ANNUAL EARNINGS	OTHER INCOME (If applicable): Commissions: _____ Bonus: _____ OverTime: _____		EFFECTIVE DATE OF DEPENDENT COVERAGE

DID THE EMPLOYEE MEET THE ACTIVELY AT WORK PROVISION IN THE POLICY?

☐ **Yes** ☐ **No** If No, Provide Details: _____

WAS EMPLOYEE ON A LAYOFF AT TIME OF INJURY?

☐ **Yes** ☐ **No** If Yes, What Was Begin Date: _____

WAS EMPLOYEE ON LEAVE OF ABSENCE AT TIME OF INJURY?

☐ **Yes** ☐ **No** If Yes, What Was The Reason: _____

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

The above statements are true and complete to the best of my knowledge. I acknowledge that Gerber Life Insurance Company may rely on the above statements as part of the Proof of Loss under the Employee Group AD&D Insurance Policy.

_____
SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE DATE

_____
PRINT NAME PHONE NUMBER

_____
ADDRESS EMAIL