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

CLAIMANT'S STATEMENT - TO BE COMPLETED BY CLAIMANT

NAME OF EMPLOYEE	NAME OF INJURED IF DIFFERENT FROM EMPLOYEE	
NAME OF EMPLOYER	ADDRESS OF EMPLOYER	POLICY NUMBER(S)

Describe how the loss occurred. For Business Travel Claims, please describe the circumstances of the business trip including purpose and location(s). Please use an additional page if needed): ______

DATE INJURED WAS FIRST TREATED BY A PHYSICIAN FOR INJURIES: ______ HAS INJURED RETURNED TO WORK? ☐ **Yes** ☐ **No**

IF YES, DATE INJURED RETURNED TO WORK: ______ IF NO, DOES INJURED INTEND TO WORK IN ANY OCCUPATION IN THE FUTURE? ☐ **Yes** ☐ **No**

NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL HEALTH CARE PROVIDERS WHO HAVE EVALUATED, EXAMINED OR TREATED THE CLAIMANT FOR ANY AND ALL CONDITIONS RELATED TO THE DISMEMBERMENT, PARALYSIS, OR DISABILITY: (IF OVERFLOW, PLEASE ATTACH LIST OF THE HEALTH CARE PROVIDERS).

NAME	ADDRESS	PHONE NUMBER
		( )
		( )
		( )

The Authorization to Use or Disclose Individually Identifiable Health Information (HIPAA)

- ☐ Please sign and date this form and attach it to the Employee's statement. Your signature on this form enables us to obtain the necessary information about you to determine your eligibility for benefits. The authorization also allows us to release information to a specific person. **You will receive a copy of the Authorization upon your request.**

For **Dependent Claims** please also provide:

- ☐ Verification of dependency - copy of birth certificate, adoption papers, guardianship, etc.
- ☐ If dependent was a student, a copy of tuition payment, school schedule, grades, etc.
- ☐ Address of dependent residence at time of loss ______

If there is a court appointed representative, please provide:

- ☐ A copy of the court document appointing Executor or Administrator
- ☐ A copy of document for a court appointed guardian for a minor's estate
- ☐ If beneficiary is a trust, a copy of the trustee appointment

For Voluntary Coverage, please provide: (The employer / policyholder may be able to assist in providing this information)

- ☐ A copy of any and all enrollment forms and/or beneficiary designation cards
- ☐ Verification of premium contributions - payroll records showing premium deductions for the date of the accident

The claimant is responsible for making sure all required forms are completed and returned to AC Newman & Co. at the address above. Processing of the claim will begin when all completed forms are received. If you have any questions, our office is available to assist you.

Please contact us Monday through Friday from 8:30 a.m. until 5:00 p.m. EST at 1(559) 252-2525.

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 them as part of the Proof of Loss under the Employee Group AD&D Insurance Policy.

CLAIMANT'S SIGNATURE	DATE
PRINT NAME	PHONE NUMBER
ADDRESS	EMAIL