

Accidental Death and Dismemberment Coverage



Accidental Dismemberment Claim Form

Submit to:
Aetna U.S. Healthcare
Life Insurance Service Center
151 Farmington Ave.
Hartford, CT 06156-3007

- Employee completes Section 1 signs Section 2.
- Employer complete Section 3.
- Physician completes the Physician Statement on the reverse side.
- Submit the completed claim form to the Aetna office that services your employer.

1. Employee Information	Name (1)	Birthdate (2)	Social Security Number (3) - -								
	Address (street, city, state, zip code) (4)		Daytime Telephone Number () (5)								
	Occupation (6)		Date of Accident (7)								
	Describe accident and give details of injuries sustained. (8)										
	List name(s), address(es), telephone number(s) of all attending physician(s). <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Doctor's Name (9)</td> <td style="width: 40%;">Address</td> <td style="width: 30%;">Telephone Number ()</td> </tr> <tr> <td> </td> <td> </td> <td>()</td> </tr> <tr> <td> </td> <td> </td> <td>()</td> </tr> </table>			Doctor's Name (9)	Address	Telephone Number ()			()		
Doctor's Name (9)	Address	Telephone Number ()									
		()									
		()									
Do you believe you are entitled to workers' compensation payments? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", state reason: (10)											
Do you carry any other accident insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", list companies: (11)											

2. Release

To all providers of health care:
 You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

3. Employer Information			
Name (12)			
Address (street, city, state, zip code) (13)			Daytime Telephone Number () (14)
Control Number (15)	Control Suffix (16)	Claim Account (17)	Plan Code (if any) (18)
Insurance Effective Date (19)	Amount of AD&D insurance in force on date of accident \$ (20)	Effective date insurance discontinued, if not in force (21)	Last contribution covered period ending (complete only if employee contributed part of premium): (22)
Date employee first began work (23)	Date employee last worked, if not working (24)	Rate of Basic Earnings on Date of Accident \$ _ (25) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	
Was accident a result of employment? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", explain fully: (26)			
Authorized Representative Signature (27)			Date (28)

For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

GC-9059 (5-96) AIF5

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Completing an Accidental Dismemberment Claim Form *(Continued)*

18. Plan code (if any) (see your Billing Statement)
19. Date the employee or dependent became covered for AD&D
20. Amount of AD&D coverage in force on the date of the accident
21. If coverage for an employee or dependent has ceased, the effective date of discontinuance
22. If the employee contributes toward the cost of AD&D coverage, the date the employee's last contribution covered them for (period ending)
23. Was the employee actually working at the time of the accident
24. If the employee was not actively-at-work at the time of the accident, the date last worked
25. The amount and method of paying the employee at the time of the accident
26. Was the accident work related? If yes, explain
27. Signature of an authorized company representative
28. Date signed

Physician's Statement:

The physician who was primarily responsible for treating the covered person's injury completes all sections, signs and dates the form.

If you need additional information concerning a claim, you may call the toll-free number for the Aetna U.S. Healthcare — Life Insurance Service Center listed in the Customer Service Information section of this manual.

