

**ACCIDENTAL DEATH, DISMEMBERMENT OR LOSS OF SIGHT CLAIM FORM**

**Claims Service Center**

P.O. Box 45153 / Jacksonville, FL 32232-5153  
Phone: 904-350-9660 / Fax 904-355-5878  
Toll Free 1-800-888-2738, Extension 8390

PLEASE ANSWER ALL QUESTIONS TO AVOID DELAY IN PROCESSING THIS CLAIM. ITEMIZED BILLS FOR ANY HOSPITAL OR TRANSPORTATION RELATED EXPENSES MUST BE ATTACHED.

**TO BE COMPLETED BY AGENT**

Full Name of Insured \_\_\_\_\_ Policy No. \_\_\_\_\_

Full Name of Policy Holder \_\_\_\_\_ Loan No. \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone No. \_\_\_\_\_

Policy Issued by: Reliable Policy Management, LLC - PO Box 100521, Florence, SC 29502-0521

Effective Date \_\_\_\_\_ Term \_\_\_\_\_ Expiration Date \_\_\_\_\_

Amount of Policy \$ \_\_\_\_\_ Amount Claimed \$ \_\_\_\_\_ Premium Paid \$ \_\_\_\_\_

Beneficiary's Name \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Does Claimant wish payment be made in a lump sum or installments? \_\_\_\_\_

**STATEMENT OF INSURED OR AUTHORIZED PERSON**

Claimant's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_ Was accident job related? \_\_\_\_\_

If answer is yes, is workman's compensation claim being filed? \_\_\_\_\_

Claim is for: Accidental Death \_\_\_\_\_ Dismemberment \_\_\_\_\_ Fracture \_\_\_\_\_ Other \_\_\_\_\_

\* IF CLAIM IS FOR ACCIDENTAL DEATH, YOU MUST ATTACH A CERTIFIED COPY OF THE DEATH CERTIFICATE OR CORONER'S REPORT.

Date of accident or injury \_\_\_\_\_ Give specific description of nature of accident and resulting injury: \_\_\_\_\_

• IF ACCIDENT OCCURRED WHILE RIDING IN OR WAS DUE TO A MOTOR VEHICLE, PLEASE ATTACH A COPY OF THE POLICE REPORT.

I certify that the answers given above are true, and I assume full responsibility for the statements given. I hereby authorize any hospital, physician, or other person who has attended or examined me, to furnish the above insurance company, or its authorized representative any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signed By \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

**Statement of Physician**  
(To be furnished without expense to Company)

1. Diagnosis: (Describe complications, if any) ICD Code \_\_\_\_\_
2. Date symptoms first appeared: \_\_\_\_\_
3. Is this a result of an accident? \_\_\_\_\_ Yes \_\_\_\_\_ No (if "yes," please describe) \_\_\_\_\_
4. Date patient first consulted you for this condition? \_\_\_\_\_
5. Name and address of any referring physician \_\_\_\_\_
6. According to history as represented to you by the patient, when did disability condition originate?  
\_\_\_\_\_  
When was diagnosis made? \_\_\_\_\_
7. GIVE ALL DATES OF TREATMENT \_\_\_\_\_
8. Is patient still under care for this condition? \_\_\_\_\_ Yes \_\_\_\_\_ No (if discharged, give date) \_\_\_\_\_
9. If patient hospitalized, give name and address of hospital.  
\_\_\_\_\_  
Hospital \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Hospital Record No. \_\_\_\_\_ Admitted \_\_\_\_\_ Discharged \_\_\_\_\_
10. How long was patient continuously and totally disabled? From \_\_\_\_\_ Through \_\_\_\_\_
11. If still disabled, date patient will be able to return to work? \_\_\_\_\_
12. Remarks, if any \_\_\_\_\_

Physicians Name & Degree (type or print) \_\_\_\_\_ Physicians Signature \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

**Statement of Employer**  
(To be completed by employer only)

1. I hereby certify that \_\_\_\_\_ was totally disabled from performing any part of his work from \_\_\_\_\_, 20\_\_\_\_\_  
Last Day of Duty
  2. Date returned to full or part-time duties: \_\_\_\_\_, 20\_\_\_\_\_
  3. Is this a Workmen's Compensation case? \_\_\_\_\_
  4. Date \_\_\_\_\_, 20\_\_\_\_\_
- Name of Employer \_\_\_\_\_
- Address \_\_\_\_\_
- Signature \_\_\_\_\_
- Official Person \_\_\_\_\_