

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_____
Last Day of Duty
3. Is this a Workmen's Compensation case? _____
4. Date _____, 20_____
Name of Employer _____
Address _____
Signature _____
Official Person _____