Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Phone Number: (866) 628-2606
Fax: (972) 996-9361

Accidental Dismemberment Claim Form
Group Life and Accidental Death Insurance

Return to Dearborn National at:
Attention: Claims Department
P.O. Box 655403
Dallas, Texas 75265-5403

INSTRUCTIONS

Upon a Dismemberment due to an Accident to an insured employee, plan member or insured dependent, the employer/administrator must complete the claim form as indicated and send with all necessary attachments.

Please submit the following documentation:

1. Claim Form:
   Part 1 – Completed by the Employer/Administrator
   Part 2 – Completed by the Insured/Claimant
   Part 3 – Completed by the Attending Physician

2. Original, photocopy or screen print of enrollment form, including any beneficiary changes.

3. If the benefits are based on salary, submit payroll records verifying the employee's annual earnings at the time of their death

4. If any portion of coverage is paid for by the employee, submit proof of payroll deduction

5. For accidental dismemberment benefits, provide the below items, including but not limited to:

   a. Official complete police report
   b. Newspaper clippings
   c. Doctor's report, including laboratory findings and or/toxicology report

6. Please have the Insured person carefully read and complete the Statement which contains information about the Dearborn National Freedom Account. Unless otherwise requested, benefits amounts of $10,000 or more will be paid using the Dearborn National Freedom Account.

The Dearborn National Freedom Account is a convenient, interest-bearing checking account into which the beneficiary's life insurance proceeds are deposited. The beneficiary earns a competitive rate of interest while taking the time to contemplate financial decisions that often follow a life changing event.

A checkbook will be mailed once the claim is approved. All Dearborn National Freedom Account accountholders will receive a monthly statement informing them of their account balance, activity and interest earnings.

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Part 1 – To be completed by Employer/Administrator

Statement of Employer
Employer/Plan Information

Group Name _____ Subsidiary Name _____

Group Number **GFZ71778**_____

Address: _____ _____ _____
Street City State/Zip

Name and Title of Authorized Representative _____

Phone Number _____ Fax Number _____

E-Mail Address _____

Insured Person Information

Employee/Claimant Name _____

If Dependent, Name of Dependent _____ Relation to Employee _____

Employee Social Security No. _____ Date of Birth _____

Address: _____ _____ _____
Street City State/Zip

Hire Date _____ Insurance Effective Date _____ Occupation _____

Annual Salary _____ Date of Last Salary Increase _____

Amount of Insurance:			Additional Benefits:	
	Basic Life	_____		_____
	Supplemental Life	_____		_____
	AD&D	_____		_____
	Voluntary Life	_____		_____
	Dependent Life	_____		_____

Last Day Worked _____ Reason for cessation of work: _____

If Disabled, Provide date of disability _____

If deceased is a dependent spouse or child, complete the following:
Dependent's most recent Employer _____ Last Day Worked _____

If dependent is a child, is he/she a full-time student? ❑ Yes ❑ No Name of School _____

I certify that I have read this document and the information is accurate and complete. I understand that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

Signature of Authorized Employer/Plan Representative _____

Print Name _____ Date _____

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Part 2 – To be completed by Insured or Claimant

Name _____
Last First Middle

Date of Birth _____ HT _____ WT _____ Social Security No. _____

Address _____
Street City State Zip

Phone _____ E-mail _____

Relationship to deceased _____

Are you a U.S. Citizen: ❑ Yes ❑ No (If No – IRS Form W-8 required)

Date of Accident_____ Date of Loss _____

Name of Treating Physician _____ Phone Number _____
(If multiple physicians, please list all. Attach separate sheet if necessary)

Location of Treating Physician _____
Address City State Zip

Name of Hospital where treatment was received _____
(If multiple hospitals, please list all. Attach separate sheet if necessary.)

Location of Hospital _____
Address City State Zip

Hospital Phone Number _____

Admission Date _____ Discharge Date _____

Describe the loss for which benefits are being claimed. (Attach separate sheet if necessary)

_____
_____
_____
_____
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_____

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Method of Payment

Dearborn National Freedom Account*

If your benefit payment is scheduled to be $10,000 or more, Dearborn National will establish an interest bearing checking account in your name, unless you have requested otherwise. The Dearborn National Freedom Account is a safe and secure interest bearing checking account into which life proceeds are deposited. With the Dearborn National Freedom Account you are able to earn a competitive rate of interest on the life insurance proceeds while taking your time to weigh the important financial decisions that often follow a life changing event.

Flexibility – During this stressful time you are given the flexibility and time to make important financial decisions and decide the best options for your financial future.

Security – All amounts are fully protected and guaranteed by Dearborn National® Life Insurance Company.

Free – As long as your account remains open, you will receive monthly statements and have access to unlimited free checks.

Accessibility – You can write checks for any amount of $250.00 or more to use as you wish.

Interest – Your account will earn interest beginning on the day it is opened. Interest is compounded daily and credited to your account each month. Your monthly statements will provide additional details on your balance.

Once your claim is approved, you will receive a checkbook and an implementation kit within 72 hours explaining the benefits of the Dearborn National Freedom Account. Once established, you will have access to 24 hour customer service.

Your implementation kit will contain the following:

- Copy of the required Privacy Letter outlining the steps we take to ensure your privacy.
- A detailed booklet containing information and frequently asked questions on the Dearborn National Freedom Account and how it works.
- A confirmation certificate containing information on your account and the benefit amount that was placed into the account.

*Not available in Rhode Island

Certification

Under penalty of perjury, I certify that:

1. The number shown on this form is my correct Social Security/Taxpayer Identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS notified me that I am not longer subject to backup withholding: and
3. I am a U.S. citizen or other U.S. person.

NOTE: Certification Instructions – You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Your Signature _____ Date _____

Printed Name _____

NOTE: Your signature as signed above will also be used to verify your signature for Dearborn National Freedom Account checks, if applicable.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Insured Name: _____ Date of Birth: _____
Last First Middle

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, autopsy (including medical and psychological reports; records, charts, notes – excluding psychotherapy notes -, x-rays, films or correspondence, and any medical condition(s);
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).
- Information to be released to: Dearborn National® Life Insurance Company
  1020 31st Street
  Downers Grove, IL 60515
- I understand the information obtained by use of this Authorization will be used by Dearborn National® Life Insurance Company (The Company) to evaluate my claim for death benefits. The Company will only release such information:
  - To its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
  - As otherwise may be required by law or as I further authorize.
- I further understand that refusal to sign this Authorization may result in the denial of benefits.
- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- I understand that I may revoke this Authorization in writing at any time, except to the extent;
  - The Company has taken action in reliance on this Authorization; or
  - The Company is using this Authorization in connection with a contestable claim.

If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signature below. To initiate revocation of this Authorization, direct all correspondence to the company at the above address.

- A photocopy of this Authorization is to be considered as valid as the original.
- I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: _____ DATE: _____

Print Name: _____

Claimant/Legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Relationship to Claimant/Insured or personal/legal representative signing for Claimant/Insured:

ADDRESS: _____ PHONE NO. _____
Street

_____
City State Zip

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Name of Patient _____ Gender _____ Date of Birth _____

Employee Name if other than Patient _____

Address _____
Street City State Zip

Date of Accident _____ Date First Consulted _____

Was the loss sustained solely as a result of this accident? _____

If No, please provide details of contributing causes. _____
_____
_____

As a result of this accident, did the patient suffer loss of any of the following? (please circle all that apply)
Hand R L Foot R L Hearing* Sight* OS OD Paralysis Other

*Is loss of sight or hearing complete and irrevocable? Yes ☐ No ☐

Please describe the loss as indicated above and provide any additional remarks:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Specialist Referral _____

Physician Name _____ Specialty _____

Address _____
Street City State Zip

Telephone _____ Fax _____ EIN/SSN _____

Signature _____ Date _____