

**National Union Fire Insurance Co of Pittsburgh, Pa**  
 CHARTIS  
 A&H Claims Division  
 P. O. Box 25987  
 Shawnee Mission, KS 66225  
 Phone 800-617-2836 Fax: 866.831.3636

**PROOF OF LOSS - ACCIDENTAL DISMEMBERMENT/PARALYSIS**

**NAME OF GROUP: NASE**  
**POLICY NUMBER: 9131328**

**GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS**

In order to assure prompt processing of this claim, please forward the claim form to the Claimant. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Claimant will be required to complete PART B. Be certain that PARTS C and D on the reverse side are completed in full and signed by the Claimant and Attending Physician, respectively. The Claimant is responsible for the completion of the Attending Physician's Statement without expense to the Company.

Return this form to the above address.

In addition to the claim form, the following items are required:

- (1) Your company's enrollment benefits form;
- (2) Confirmation of employee's principal sum and current premium payment;
- (3) Information on other insurance;
- (4) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of the trip, destination to and from trip, and confirmation that trip was authorized by the company.
- (5) Please provide company name, address, phone number, and policy number.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary.

**PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION**

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS			DATE EMPLOYED		
EMPLOYEE/MEMBER NAME AND ADDRESS			DATE OF ACCIDENT		
EFFECTIVE DATE OF COVERAGE	EMPLOYEE/MEMBER SOCIAL SECURITY NUMBER	DATE OF BIRTH	EMPLOYEE/MEMBER OCCUPATION		
TERMINATION DATE OF COVERAGE	INSURANCE CLASS	SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY)		DATE PREMIUM PAID TO	
ACCIDENTAL DEATH BENEFIT IN FORCE	DATE OF LAST BENEFIT INCREASE	IS EMPLOYEE/MEMBER RECEIVING W.C. BENEFITS?		IS EMPLOYEE/MEMBER RECEIVING ANY OTHER INSURANCE?	
\$		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
IF EITHER ANSWER IS YES, INDICATE NAME OF COMPANY:		ADDRESS OF COMPANY			
POLICY NUMBER	PHONE NUMBER	TYPE OF BENEFIT, BENEFIT AMOUNT, EFFECTIVE DATE			
STATUS OF EMPLOYEE/MEMBER ON DATE LAST WORKED					
<input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> PREMIUM WAIVER FOR DISABILITY <input type="checkbox"/> APPROVED LEAVE OF ABSENCE (EXPLAIN) <input type="checkbox"/> OTHER					
DATE EMPLOYEE/MEMBER LAST WORKED	REASON EMPLOYEE/MEMBER DID NOT RETURN TO WORK				
EMPLOYEE/MEMBER WAS: <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED <input type="checkbox"/> COMMISSIONED <input type="checkbox"/> OTHER (EXPLAIN)					

**If Claim is For Dependent, Provide the Following:**

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT
DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER	

**GROUP POLICYHOLDER/EMPLOYER SIGNATURE**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER
GROUP POLICYHOLDER/EMPLOYER		BY (THEIR AUTHORIZED REPRESENTATIVE)

**PART B: IMPORTANT TAX INFORMATION**

**To Be Completed by Claimant**

Social Security Number/ Tax ID Number

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**Please Print or Type Name of Claimant**

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.  
**Be Certain Part C on the Reverse Side is Completed**

**PART C: CLAIMANT INFORMATION**

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY) DESCRIBE INJURIES RECEIVED.

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED EMPLOYEE/MEMBER FOR THESE INJURIES

Table with 3 columns: NAME, ADDRESS, PHONE NUMBER. Two rows for listing physicians.

LIST ALL WITNESSES TO ACCIDENT

Table with 3 columns: NAME, ADDRESS, PHONE NUMBER. Two rows for listing witnesses.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

**AUTHORIZATION**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature and contact information fields: SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE, DATE SIGNED (MONTH, DAY, YEAR), ADDRESS OF CLAIMANT, BUSINESS PHONE NUMBER, HOME PHONE NUMBER.

**PART D: ATTENDING PHYSICIAN'S STATEMENT**

THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION OF THIS STATEMENT WITHOUT EXPENSE TO THE COMPANY.

Table with 3 columns: NAME OF PATIENT, AGE, ADDRESS (STREET, CITY, STATE, ZIP CODE).

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID ACCIDENT HAPPEN? (MO., DAY, YEAR) WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MO., DAY, YEAR)

Table for injury details: DID THE ACCIDENTAL INJURY RESULT IN: LOSS OF HANDS?, LOSS OF THUMB AND INDEX FINGER OF SAME HAND?, LOSS OF FEET?, TOTAL AND IRRECOVERABLE, LOSS OF SIGHT OF: RIGHT EYE, LEFT EYE, TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS? Includes checkboxes for YES/NO and fields for DATE OF SEVERANCE and DATE REMOVED.

Table for vision and surgery: PARALYSIS, QUADRIPLEGIA, PARAPLEGIA, HEMIPLEGIA, IN YOUR OPINION, WAS ANY DISEASE, INFECTION, BODILY OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?, IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION?, IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGHT, PLEASE ANSWER THE FOLLOWING QUESTIONS: UNCORRECTED, CORRECTED, DATE OF EXAMINATION, DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR OPERATION?, IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE., WAS PATIENT CONFINED TO A HOSPITAL?

Table for treatment and physician info: TREATMENT, DATE OF FIRST VISIT, DATES OF SUBSEQUENT VISITS, SIGNATURE OF ATTENDING PHYSICIAN, PHYSICIAN'S NAME (PLEASE PRINT), DEGREE, TELEPHONE, DATE, STREET ADDRESS, CITY OR TOWN, STATE OR PROVINCE, ZIP CODE, IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?, IF DISCHARGED, GIVE DATE OF DISCHARGE.