Proof of Loss for Benefits Under Dismemberment and Loss of Sight Insurance

LifeWise Assurance Company
P.O. Box 2272
Seattle WA 98111-2272
(425) 918-4575

LIFEWISE
ASSURANCE COMPANY
Life | Disability | Stop Loss

EMPLOYEE STATEMENT

NAME	SOCIAL SECURITY NUMBER	AGE

WHERE DID INJURY OCCUR?	DATE AND HOUR OF INJURY
	/ / |

WHAT WERE YOU DOING?

PLEASE DESCRIBE THE INJURY

NAMES OF PHYSICIANS CONSULTED	NAME	DATE / / | ADDRESS
		/ / |
		/ / |
		/ / |
		/ / |

WERE YOU CONFINED TO A HOSPITAL?
☐ YES ☐ NO WHERE?

DATES
FROM _____/_____/_____ TO _____/_____/_____

NAMES AND ADDRESSES OF TWO WITNESSES TO THE ACCIDENT	NAME	ADDRESS

DATED _____/_____/_____ EMPLOYEE

EMPLOYER STATEMENT

NAME OF EMPLOYER	POLICY NO.
NAME OF EMPLOYEE	AMOUNT OF INSURANCE $
ADDRESS	DATE OF BIRTH / /
WAS HE OR SHE IN YOUR EMPLOYMENT AT TIME DISABILITY BEGAN? ☐ YES ☐ NO	DATE EMPLOYED / /
DATE ON WHICH HE OR SHE LAST WORKED FULL-TIME AND PAY / /	WHEN DID EMPLOYEE STOP WORK? (DATE) / / | (TIME)
WHEN DID EMPLOYEE RETURN TO WORK? (DATE) / / | (TIME)	IF NOT BACK TO WORK, WHEN DO YOU EXPECT HIM OR HER TO RETURN? / /

HAS EMPLOYEE MADE CLAIM FOR WORKER'S COMPENSATION? ☐ YES ☐ NO IS HE OR SHE ENTITLED TO SUCH BENEFITS? ☐ YES ☐ NO

DID INJURY OR ILLNESS ARISE OUT OF OR IN THE COURSE OF OCCUPATIONAL EMPLOYMENT FOR WAGES OR PROFIT? ☐ YES ☐ NO

DO YOU RECOMMEND PAYMENT OF THIS CLAIM? ☐ YES ☐ NO

REMARKS:

DATED / / EMPLOYER'S SIGNATURE AND TITLE

(OVER)

To Be Furnished Without Expense To The Company

ATTENDING PHYSICIAN STATEMENT

PATIENT NAME		AGE
NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)		
DATE OF ACCIDENT / /	NATURE OF SURGICAL PROCEDURE, IF ANY (DESCRIBE BRIEFLY)	
DATE PERFORMED / /	WHERE PERFORMED	IF IN HOSPITAL ☐ INPATIENT ☐ OUTPATIENT
GIVE DATES OF TREATMENTS	OFFICE	
	HOME	
	HOSPITAL	
IF DISEASE, DEFORMITY, INFIRMITY OR AN INTOXICANT WAS A CONTRIBUTING FACTOR TO EITHER THE ACCIDENT OR THE INJURY, PLEASE STATE HOW AND TO WHAT EXTENT.		
HAVE YOU FURNISHED A SIMILAR REPORT TO ANY OTHER INSURANCE COMPANIES? ☐ YES ☐ NO		
IS LOSS OF VISION IRRECOVERABLE? ☐ YES ☐ NO REMARKS		
DATED / / PHYSICIAN SIGNATURE , M.D.		
( )		
ADDRESS TELEPHONE		

Authorization to Release Information

I hereby certify that the above statements are true and complete to the best of my knowledge.

I request and authorize any provider of health care, agent, insurance company, physician or hospital having knowledge information or records relating to my claim for insurance benefits with LIFEWISE ASSURANCE COMPANY to disclose and furnish any information or records including drug, alcohol or psychiatic, required by the Company for the purpose of evaluating and processing my claim to LIFEWISE ASSURANCE COMPANY or its representatives.

I understand my right to secure a copy of this authorization at any time. A photocopy of this authorization is as valid as the original and will be effective for six months from the date signed below.

(Witness to Claimant Signature) (Signature of Claimant)

Signed this the _____ day of _____, ⌊__⌋__⌋__⌋__⌋.