

Claimant's Proof of Accident

Fidelity Life Association, A Legal Reserve Life Insurance Company
P.O. Box 9269
Oak Brook, IL 60522-9269



IMPORTANT – If the Insured is below age 15, this Proof of Accident Claim must be signed (in the space marked X) by the Original Applicant who applied for the insurance as indicated on the photo copy of the application included in the policy.
If the Insured is above age 15, then the Insured must sign in the space marked X.

Section 1: Patient's Information

Full Name of Insured _____ Date of Birth _____

Policy No.(s) _____ Branch No. _____

1. What was the nature of the accidental injury?

2. What was the cause of the injury?

3. Where did injury take place? City _____ State _____

4. Give date the injury took place. ____ / ____ / ____

5. Insured's occupation at time of injury?

6. Was an x-ray photo taken of the injury? Yes No

7. What is the amount of your accident claim?

(To determine this amount, read carefully the provisions of the Dismemberment and Fracture section of the Policy) \$ _____

8. Give names and addresses of those present when accidental injury occurred. If more than one, give name and address of each.

Name and Address _____

Name and Address _____

Name and Address _____

9. Give name and address of attending physician. If more than one, give name and address of each

Name _____ Date of Attendance ____ / ____ / ____

Address _____

Name _____ Date of Attendance ____ / ____ / ____

Address _____

Name _____ Date of Attendance ____ / ____ / ____

Address _____

Section 2: Information Authorization

I hereby make claim for the above amount in item 7 and declare the foregoing answers and statements to be correct and true. I hereby authorize any physician or other person who has attended or may attend the Insured to disclose any information regarding such injury.

Date at _____ this _____ day of _____, 20_____

Signature of Witness _____

Signature of Claimant _____

X

Claimant Street Address _____

City _____ State _____ Zip _____

STATE OF _____ COUNTY OF _____ SS: _____

On this _____ day of _____, 20_____, personally appeared before me at _____

State of _____, the above Claimant, who is known to me and who subscribed the foregoing statement before me and stated under oath that the statements and answers above made and subscribed are true and full.

In Witness Whereof, I have hereunto subscribed my name and affixed my official seal. (Seal)

My Commission Expires _____

THIS PROOF OF ACCIDENT NEED NOT BE NOTARIZED IF WITNESSED BY A REPRESENTATIVE OF THE ASSOCIATION

Established 1896

Fidelity Life Association

1211 West 22nd Street, Suite 209

Oak Brook, IL 60523

Tel 630.522.0392

Fax 630.522.0397

Attending Physician's Statement**Accident or Sickness****(Individual Hospital or Surgical)****Section 1: Patient's Information**

Patient's Name _____

Date of Birth _____

1. Nature of Sickness or Injury (Describe complications if any)Is condition due to pregnancy? Yes No

If "yes," what was approximate date of commencement of pregnancy? ____ / ____ / ____

2. When did symptoms first appear or accident happen? ____ / ____ / ____**3. When did patient first consult you for this condition?** ____ / ____ / ____**4. Has patient ever had same or similar condition? (If "yes", state when and describe)** Yes No**5. Nature of surgical procedure or obstetrical procedure, if any. (Describe fully)**

Where performed: _____

If in hospital: In-patient Out-patient

Charge for this procedure and date performed: \$ _____ Date ____ / ____ / ____

6. Give dates of treatment.

Office _____ Date ____ / ____ / ____ Charge \$ _____

Home _____ Date ____ / ____ / ____ Charge \$ _____

Hospital _____ Date ____ / ____ / ____ Charge \$ _____

7. Is further operative procedure anticipated? (If "yes," explain) Yes No

8. Is condition due to injury or sickness arising out of patient's employment? (If "yes," explain) Yes No

9. Is patient still under your care for this condition? Yes No If discharged, give date: ____ / ____ / ____

10. If fracture or dislocation, state whether complete or incomplete.

Is fracture of long bones, state type and location.

Was it confirmed by X-ray Yes No

Section 2: Additional Remarks

Section 3: Signature

Physician or Surgeon (Please type or print) _____ Signature of Physician or Surgeon _____

Date _____ Phone _____

City _____ State _____ Zip _____

Individual Hospital Insurance Form

Fidelity Life Association, A Legal Reserve Life Insurance Company
P.O. Box 9269
Oak Brook, IL 60522-9269

Section 1: Patient's Information

Name of Policyholder

Street Address

City

State

Zip

Policy Number

Name of Patient (if other than Policyholder)

Date of Birth

Relationship

AM PM

AM PM

Date and Time Admitted to Hospital

Date and Time Discharged from Hospital

Complaint

Date of First Symptoms

Diagnosis From Records (if Injury, Give Date and Place of Accident)

Operations or Obstetrical Procedures Performed (Nature and Date)

Section 2: Hospital Charges

Complete this section or attach copy of itemized bill showing type of accommodations.

Room & Board

Ward _____ days at \$ _____

Total \$ _____

Semi-Private _____ days at \$ _____

Total \$ _____

Private _____ days at \$ _____

Total \$ _____

Other Charges

Anesthesia

\$ _____

Operating or Delivery Room

\$ _____

Laboratory

\$ _____

X-Ray

\$ _____

Dressing

\$ _____

Drugs

\$ _____

Oxygen

\$ _____

EKG BMR

\$ _____

\$ _____

Total \$ _____

Hospital

Street Address

City

State

Zip

Taken from Records (Date)

Signed by

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release the information requested on this form

Date

Signed (Patient - Parent if a Minor)

Section 3: Assignment of Insurance Benefits

I hereby authorize payment directly to the above named hospital of the Hospital Benefits otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the hospital for charges not covered by this assignment.

Date

Policyholder Signature