MEDMUTUAL LIFE™
A Medical Mutual Company
15885 W. Sprague Road, Strongsville, Ohio 44136-1772

Accident Claim Form

Telephone: 866-925-2542
Fax: 440-878-6916
Email Address: Claims@medmutual.com

Type of Claim Being Submitted: ☐ Dismemberment ☐ Coma Benefit

Group Number

Claimant's Statement *(Please print)*

Name	Social Security No.	Height	Weight	Date of Birth
				/ /

Address
Number Street City State Zip

Home Telephone Number
( )

Name of Employer	Occupation	Home Email Address (optional)

Is this a work related injury? ☐ Yes ☐ No
Have you filed a claim for this injury under the Workers' Compensation Act? ☐ Yes ☐ No

Date of Accident: ____ /____ /____ Date Last Worked: ____ /____ /____

Describe the Injury: _____

Describe how and where the accident occurred*: _____

_____

**If due to a motor vehicle accident or crime, please include a copy of the Police Report. If due to other accident type, please include any supporting documentation (newspaper clippings, witness statements, Employer OSHA accident report, etc.)*

Name and address of Physician(s) and/or Hospital(s) that provided treatment immediately following the accident:

_____

_____

Name and address of any other Physician(s) and/or Hospital(s) that have provided treatment for this injury:

_____

_____

I authorize my employer to disclose all information necessary to process my claim to MedMutual Life Insurance Company (MedMutual Life). I hereby authorize any medical professional, hospital, medical facility, medical provider, clinic, pharmacy, Government Agency, Insurance Company or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to MedMutual Life's claim department or its authorized representative(s) information about my medical history or treatment for any condition, including but not limited to drug or alcohol abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases. I further authorize MedMutual Life to disclose the information obtained in the consideration of my claim for insurance to its reinsurers.

I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on prior actions taken by MedMutual Life;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy is as valid as the original;

I, as well as any other person authorized to act on my behalf, acknowledge the right upon request to obtain a true copy of my authorization from MedMutual Life.

If my answers on this claim form are incorrect or untrue, or if I refuse to sign this authorization, MedMutual Life has the right to deny my claim. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR 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. (Not enforceable in Oregon or Virginia.)

_____ _____
Signature of Employee or Employee's Representative Date

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Employer's Statement

Employee's Name	Social Security No.	Hire Date	Insurance Eff. Date	Occupation

Employer's Name and Address	Employer's Email Address

Date Last Worked	Date Returned	Base Salary	Hours Worked Per Week	Amount of Life Insurance in Force	Premium Paid to Date

Signature	Title	Date	Telephone Number	Fax Number

Attending Physician's Statement *(Please print)*

(Must be completed in full at no expense to MedMutual Life)

Patient's Name	Address	Date of Birth / /	☐ Male ☐ Female

Date of Accident: ____ /____ /____ Is this a work related injury? ☐ Yes ☐ No

Describe the accident causing the injury/impairment: _____

_____

Describe the injury/impairment: _____

_____

Date patient first consulted you for this injury: ____ /____ /____ Most recent treatment date: ____ /____ /____

Was there a disease or condition prior to the accident that may have served as a contributing factor? ☐ Yes ☐ No

If yes, please describe: _____

Give all surgery dates and procedures relating to this injury: _____

_____

Has patient been hospitalized? ☐ Yes ☐ No If yes, dates of confinement: ____ /____ /____ to ____ /____ /____

Name and address of hospital: _____

Is patient still under your care? ☐ Yes ☐ No If no, give discharge date and degree of recovery:

_____

Is patient under the care of another physician? ☐ Yes ☐ No If yes, provide name and address:

_____

Is patient in a coma? ☐ Yes ☐ No If yes, please advise: Date of onset of coma: ____ /____ /____

Date last observed as comatose: ____ /____ /____

Physician Signature: _____ Date: ____ /____ /____

Name *(Please Print)*: _____ Specialty: _____

Address: _____

Telephone Number: _____ Fax Number: _____

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Fraud Notices

The laws of some states require us to furnish you with the following notice:

For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington; WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS – 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.

FLORIDA RESIDENTS – Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS – Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

VIRGINIA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.