Claimant's Proof of Accident

Fidelity Life Association, A Legal Reserve Life Insurance Company
P.O. Box 5030
Des Plaines, Illinois 60017

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 is the nature of the accidental injury?

____

2. What was the cause of the injury?

____

3. Where did the 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 ____________.

____ **X** ____

Signature of Witness Signature of Claimant

____

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

Attending Physician's Statement
Accident or Sickness (Individual Hospital or Surgical)

Established 1896

Innovation Is Our Policy

Fidelity Life Association
8700 W. Bryn Mawr Ave., Ste. 900S
Chicago, IL 60631
Tel 800-369-3990
Fax 866-375-8175

Section 1: Patient's Information

______________________________ ______________
Patient's Name Date of Birth

1. Nature of Sickness or Injury (Describe Complications if any)

____

Is this 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.

____

If 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 5030
Des Plaines, Illinois 60017

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 | Dated 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

AUTORIZATION TO RELEASE INFORMATION: I hereby authorize the above named hospital to release the information requested on this from.

Date | Signed (Patient or Parent if 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