DISMEMBERMENT CLAIM FORM

Merit Life® INSURANCE CO.
A Stock Company Domiciled in Indiana

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Complete **SECTION 1**
2. Read, sign and date **SECTION 2**
3. Print your name and your policy number in **SECTION 3**
4. The physician who can verify your dismemberment or loss must complete **SECTION 4**
5. Read, sign and date **SECTION 5**
6. Send **BOTH PAGES** of the completed, signed claim form and any attachments to Merit Life Insurance Claims Department. Keep a copy for your records.

If you need assistance with this form, contact Merit Life Insurance Co. at 1-800-325-2147, ext 5113292.

SECTION 1 TO BE COMPLETED BY CLAIMANT (PLEASE PRINT)

FIRST	MI	LAST
MAILING ADDRESS		
CITY	STATE	ZIP
DAYTIME PHONE # ( )	EMAIL ADDRESS (OPTIONAL)	
DATE OF BIRTH	SOCIAL SECURITY #	
POLICY #		
DATE OF ACCIDENT	DATE OF DISMEMBERMENT/LOSS OF VISION	
CAUSE OF DISMEMBERMENT/LOSS OF VISION		

SECTION 2 AUTHORIZATION TO RELEASE INFORMATION

By signing below, I authorize the release and disclosure of any of my information; including but not limited to: personal information, diagnosis(es), medical condition(s) and any reports that will aid the Insurance Company with its investigation of my claim with any party. I authorize any physician, hospital, medical or medically related facility or any other individual or facility where I have been treated, examined, admitted, or confined to release information concerning my medical history, mental or physical condition(s), or treatment which may be requested by the Insurance Company or its duly authorized representative for the purpose of determining my eligibility for the benefits I have requested. I authorize any employer, insurer, or other individual or organization, including but not limited to: Social Security Administration or Railroad Retirement Board, having any records, files, reports, etc., concerning me to release the information to the Insurance Company or its duly authorized representative for the purpose of determining my eligibility for the benefits I have requested. This authorization shall remain valid for one year from the date I have signed below. However, I have the right to revoke this authorization in writing within one year from the date of my signature. A photocopy of this authorization shall be valid as the original and I or my authorized representative shall receive a copy of this authorization.

CLAIMANT SIGNATURE: _____ **DATE:** _____

SECTION 3 TO BE COMPLETED BY CLAIMANT (PLEASE PRINT)

CLAIMANT NAME _____ **POLICY #** _____

SECTION 4 TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT) (completed without expense to Merit Life)

PATIENT'S NAME FIRST MI LAST
DIAGNOSIS ICD CODE(S)
DESCRIBE OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION
ILLNESS ☐ ACCIDENT ☐ DATE INCURRED FIRST CONSULT DATE FOR THIS CONDITION
WAS PATIENT TREATED PREVIOUSLY FOR ANY CONDITION, DISORDER, OR OLD INJURY AFFECTING THE LOSS? YES ☐ NO ☐
IF YES, PROVIDE DESCRIPTION/DETAILS
NAME AND ADDRESS OF PHYSICIAN(S) WHO **PREVIOUSLY** TREATED PATIENT FOR THE ABOVE CONDITION
LOSS OF SIGHT, COMPLETE THIS SECTION DATE SIGHT LOST
CURRENT DEGREE OF VISION LEFT EYE / RIGHT EYE / LOSS OF SIGHT IRRECOVERABLE YES ☐ NO ☐
LOSS OF LIMB, COMPLETE THIS SECTION DATE OF DISMEMBERMENT
SEVERANCE AT OR ABOVE WRIST/ANKLE YES ☐ NO ☐ SEVERED HAND(S) LEFT ☐ RIGHT ☐ SEVERED FOOT LEFT ☐ RIGHT ☐
NAME OF HOSPITAL CITY STATE
PHYSICIAN'S PHONE # ( ) PHYSICIAN'S FAX # ( )
PHYSICIAN'S EMAIL ADDRESS
PHYSICIAN'S PRINTED NAME FIRST MI LAST

PHYSICIAN'S SIGNATURE _____ DEGREE _____ TODAY'S DATE _____

SECTION 5 INSURANCE FRAUD WARNING

For your protection, where applicable, State law requires the following statement to appear on this form. Any person who knowingly and with intent to defraud, files an application for insurance or statement of claim containing any materially false or fraudulent information, or knowingly conceals material information for the purpose of misleading, may be guilty of a crime and subject to denial of coverage, fines, confinement in prison and/or civil penalties.

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.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA

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

KENTUCKY AND PENNSYLVANIA

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.

I HAVE READ AND UNDERSTAND THE INFORMATION ON BOTH PAGES OF THIS FORM. I AFFIRM THE INFORMATION I PROVIDED HEREIN IS ACCURATE AND COMPLETE.

CLAIMANT SIGNATURE: _____ **DATE:** _____

MAIL TO: **MERIT LIFE ISURANCE CO.**
601 N.W. SECOND STREET, P.O. BOX 39
EVANSVILLE, IN 47701-0039

OR FAX TO: **1-800-350-9582**

OR EMAIL TO: **InsClaims@onemainfinancial.com**