OneMain Solutions®

Underwritten by:
Merit Life Insurance Company
P.O. Box 2548, Fort Worth, TX 76113-2548
Toll Free 800-307-0048 / Fax 800-350-9582
insclaims@omf.com

Insured's Name: _____ Account/Policy # _____

Accidental Dismemberment Claim Form

Claim # _____
(if available)

Important Information

For Arizona residents only: "For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

For California residents only: "For your protection California law requires the following to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

For Pennsylvania residents only: "Any person who, with the intent to defraud, knowingly submits an application to or files a claim with an insurance company or other person containing false, incomplete, misleading or deceptive facts, statements or information may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that can include fines and confinement in prison."

For residents of other states (NOTE: None of these notices apply to Oregon 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 subjects such person to criminal and civil penalties."

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1. Read, complete, sign, and date all applicable portions of the Statement of Insured.
2. The physician who can verify your disability must complete the Physician's Statement.
3. Send all pages of the completed, signed claim form and any attachments to Insurance Claims Department shown above. Keep a copy for your records. Please be aware email is not considered a secure method of delivery for personal / medical information.

Note: Altered forms cannot be accepted.

Statement of Insured - To be completed by Insured

Name

Complete mailing address **City** **State** **Zip**

Date of birth (MM / DD / YY) **Telephone #** **Last 4 of SSN**

Email address (optional)

Date of accident ☐☐ / ☐☐ / ☐☐

Date of dismemberment / loss of vision ☐☐ / ☐☐ / ☐☐

Cause of dismemberment / loss of vision

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA) Privacy regulations, 45 CFR § 164.508, I hereby authorize any employer, physician, hospital, clinic, other medical or medically related facility, the Medical Information Bureau Inc., consumer reporting agency, insurance or reinsuring company, insurer, law enforcement agency, fire department, Social Security Administration, Railroad Retirement Board, Veterans Administration or any other organization or person having any records, data, or information concerning this claim to furnish such record, data, or information to above or any of its representatives for purposes of processing this claim.

I understand and acknowledge that this authorization extends to all or any part of the records being requested, which may included treatment for physical and mental illness (except for psychotherapy notes which must be requested by separate authorization), alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis and treatment. Initials ☐

This authorization shall be valid for the duration of the claim. I have the right to revoke this authorization by providing a signed and dated, written notice to the insurance company above. Once this authorization is revoked, protected health information subject to this authorization will not be used or disclosed except to the extent that this authorization has already been relied upon. I understand that in executing this authorization the information disclosed may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance and Portability and Accountability Act (HIPPA). I understand that I have the right to retain a copy of this authorization and to inspect and receive any information disclosed under its terms. A photocopy of this authorization shall be considered as effective and valid as the original.

I affirm the information I have provided herein is accurate and complete. Signature below is the Claimant or legal representative.

Signature **Date**

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Claim # _____ (if available)

Accidental Dismemberment Claim Form - Statement of Attending Physician - To be completed by Attending Physician **Completed without expense to the company.**

☐ **Illness** ☐ **Accident** **Date incurred** ☐☐ / ☐☐ / ☐☐

Primary diagnosis **ICD code(s)**

Contributing cause/complications of disability

Has patient ever had the same or similar condition ☐ **Yes** ☐ **No** **If yes, when** _____

Date symptoms first appeared or accident occurred

Name and address of physician(s) who previously treated patient for above condition

IF LOSS OF SIGHT **Date of loss** ☐☐ / ☐☐ / ☐☐ **Is loss irrecoverable** ☐ **Yes** ☐ **No**

Current degree of vision

Left Eye / **Right Eye** /

IF LOSS OF LIMB **Date of dismemberment** ☐☐ / ☐☐ / ☐☐

Severance at or above wrist / ankle ☐ **Yes** ☐ **No** **Severed hand(s)** ☐ **Right** ☐ **Left** **Severed foot** ☐ **Right** ☐ **Left**

Name of hospital

Signature of attending physician **Date**

Complete mailing address **City** **State** **Zip**

Telephone # **Fax #**

Email address