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www.ufcwtrust.com

# CLAIM STATEMENT – DISMEMBERMENT OR LOSS OF SIGHT

NAME OF MEMBER: ______________________________ ____________
(LAST) (FIRST) (MIDDLE) SSN OR ID#

NAME OF PATIENT: ____________________ ____________ ____________
(LAST) (FIRST) RELATIONSHIP TO EMPLOYEE DATE OF BIRTH

DATE OF ACCIDENT OR ILLNESS: ______________
(MM/DD/YYYY)

IF ACCIDENT, PLACE OF ACCIDENT: ______________________
(CITY) (STATE)

DESCRIBE FULLY HOW THE ACCIDENT OCCURRED, THE NATURE OF INJURIES RECEIVED AND LOSS(ES) FOR WHICH CLAIM IS MADE:

______________________________________________________

______________________________________________________

______________________________________________________

DID THE LOSS OCCUR IN CONNECTION WITH YOUR EMPLOYMENT? ☐ YES ☐ NO

DATE OF SURGICAL PROCEDURE: ______________
(MM/DD/YYYY)

NAME AND ADDRESS OF ATTENDING PHYSICIAN(S)

NAME: ______________________________ ______________
(LAST) (FIRST) (MIDDLE) PHONE NUMBER

ADDRESS: ______________________________________________
(STREET) (CITY) (STATE) (ZIP CODE)

NAME: ______________________________ ______________
(LAST) (FIRST) (MIDDLE) PHONE NUMBER

ADDRESS: ______________________________________________
(STREET) (CITY) (STATE) (ZIP CODE)

**MEMBER SIGNATURE:** ______________________________ DATE: ______________
(MM/DD/YYYY)

(SEE REVERSE SIDE FOR PHYSICIAN'S STATEMENT)

# ATTENDING PHYSICIAN'S STATEMENT

NAME OF PATIENT: ______________________________ ______________
(LAST) (FIRST) DATE OF BIRTH

1. NATURE OF LOSS (IF AMPUTATION, SEE NOTE BELOW): ______________________________

______________________________

2. IF LOSS OF SIGHT INVOLVED, IN YOUR OPINION IS LOSS OF SIGHT COMPLETE AND IRRECOVERABLE? ☐ YES ☐ NO

   IF YES, PLEASE GIVE DATE WHICH SUCH LOSS BECAME COMPLETE AND IRRECOVERABLE: ______________
   (MM/DD/YYYY)

3. IN YOUR OPINION WAS LOSS DUE TO ACCIDENT? ☐ YES ☐ NO IF YES, GIVE DETAILS: ______________

______________________________

______________________________

______________________________

4. IF INJURY OR DISEASE REQUIRED SURGICAL OPERATION, GIVE A DESCRIPTION OF OPERATION AND DATE PERFORMED:

______________________________

______________________________

______________________________

5. IN YOUR OPINION WAS ANY DISEASE AN UNDERLYING CAUSE IN THIS LOSS? ☐ YES ☐ NO

   IF YES, PLEASE EXPLAIN: ______________________________

   ______________________________

6. WAS PATIENT CONFINED TO HOSPITAL AS A RESULT OF LOSS? ☐ YES ☐ NO

   (A) IF YES – NAME OF HOSPITAL: ______________________________

   (B) AS IN-PATIENT ☐ AS OUT-PATIENT ☐

ATTENDING PHYSICIAN'S NAME: ______________________________
(LAST) (FIRST) (MIDDLE)

ADDRESS: ______________________________
(STREET) (CITY) (STATE) (ZIP CODE)

ATTENDING PHYSICIAN'S SIGNATURE: ______________________________ ______________
PHONE NUMBER

DATE: ______________
(MM/DD/YYYY)

NOTE: IF AMPUTATION, PLEASE INDICATE ON DIAGRAM SHOWING SITE(S) OF AMPUTATION