

**Statement of Claim for  
Accidental Dismemberment Benefits and Additional Benefits**

**TO THE EMPLOYER/RECORDKEEPER**

**WHEN THIS FORM SHOULD BE COMPLETED**

You should **always** complete this form when the insured or covered dependent suffers an accidental injury that results in a covered loss other than death. Completion of a separate life insurance claim form is not necessary.

Please note that this form may include benefits that are not part of your plan; MetLife will review the claim in accordance with your specific plan provisions.

**INSTRUCTIONS FOR COMPLETION**

1. Complete **Employer's Statement** and provide the entire form to the claimant.
2. Instruct the claimant to complete **Claimant's Statement**, and submit the entire form, plus any additional documents and forms, such as the **Attending Physician Statement** to MetLife.
3. Contact the MetLife Administrator responsible for your group if you have further questions.

**TO THE CLAIMANT**

To ensure that you have knowledge of all of the benefits that are included in the Group Accidental Dismemberment (AD&D) plan, this claim form is being provided to you.

The employer has completed the **Employer's Statement**. The Description of Benefits below provides a list of benefits that may be available under AD&D plans ; however please be aware that your particular plan may not include all of these benefits. Please refer to your group certificate or Summary Plan Description for specific plan details.

To file a claim for AD&D benefits, complete the **Claimant's Statement**. Your claim may also require that your physician complete an **Attending Physician's Statement**.

Upon completion, send all parts of the form to MetLife:

**MetLife  
Group Life Claims  
P.O. Box 6100  
Scranton, PA 18505  
1-800-638-6420**

Upon receipt, your claim will be thoroughly reviewed. It may be necessary for MetLife to request additional information before a final determination is made.

**DESCRIPTION OF BENEFITS**

If the insured suffers an accident and meets the conditions for any of the benefits listed below, and if that benefit is included in the employer's plan, an accidental dismemberment benefit or additional amount may be payable.

Refer to your group certificate or Summary Plan Description for a complete description of these benefits. Not all plans include these benefits.

- Permanent and Irreversible Brain Damage
- Third Degree Burn
- Coma
- Unavoidable Exposure to the Elements
- Limb/Digit Amputation
- Entire and Irrevocable Loss of Hearing in Both Ears
- Entire and Irrevocable Loss of Speech
- Permanent and Uncorrectable Loss of Vision in One or Both Eyes
- Complete, Permanent and Irreversible Paralysis
- Rehabilitative Physical Therapy

**Statement of Claim for  
Accidental Dismemberment Benefits and Additional Benefits**

<b>Employer's Statement</b> (To be Completed by the Employer) (Please Answer All Questions)			
Name of Insured Employee (First, Middle, Last)		Employee Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	Date of Accident	Date of Loss (if applicable)	
Date of Hire	Basic Annual Earnings as of Date \$ _____		
Employee is: <input type="checkbox"/> Hourly or <input type="checkbox"/> Salaried <input type="checkbox"/> Union or <input type="checkbox"/> Non-Union <input type="checkbox"/> Exempt or <input type="checkbox"/> Non-Exempt		Was Insurance ever assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please attach a copy of assignment and all related papers)	
Employee's full amount of VAD&D Insurance \$ _____		Report # _____	Sub _____ Branch _____
Employee's full amount of AD&D Insurance \$ _____		Report # _____	Sub _____ Branch _____
Employee's full amount of OAD&D Insurance \$ _____		Report # _____	Sub _____ Branch _____
Employee's full amount of DAD&D Insurance \$ _____		Report # _____	Sub _____ Branch _____
<input type="checkbox"/> Active Employee	Effective date of amount claimed	<input type="checkbox"/> Retired Employee	Date Retired
If the employee was not actively at work at date of death or loss, please indicate status (Choose one):			
<input type="checkbox"/> Regular Retiree		<input type="checkbox"/> Retired Due to Disability	
<input type="checkbox"/> Terminated for any Other Reason		<input type="checkbox"/> Leave of Absence/Layoff/Sick Leave	
		<input type="checkbox"/> Terminated Due to Disability	
		<input type="checkbox"/> Disabled (Not terminated or retired)	
Date Last Worked	Reason for Stopping		
Date Premium Payments for Employee Stopped	Was Life Insurance Cancelled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	
Was the Employer/Employee relationship terminated before the death or loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Reason	
Was a Total and Permanent Disability or Continued Protection (CP) disability waiver claim ever filed with MetLife for this employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Disability Case Number	

<b>Dependent Claim Only</b>		
Date of Loss (if applicable)	Date of Birth	Dependent Social Security Number
Relationship (Spouse/Child)	Name of Dependent (First, Middle, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		

Employer Name _____	Phone No. _____
(Area Code)	
Address _____	
Date Signed _____	Print Name _____
Signature of Employer Representative _____	

# MetLife

Metropolitan Life Insurance Company

**Group Life Claims**

**P.O. Box 6100**

**Scranton, PA 18505-6100**

**1-800-638-6420**

Dear Claimant:

To help you through what can be a difficult time, Metropolitan Life Insurance Company (MetLife) created a settlement option, the Total Control Account<sup>®</sup> Settlement Option (TCA) to give you the time you need to best decide how to use your insurance or annuity proceeds. Your TCA is an insurance Settlement Option, which is a method of paying insurance or annuity benefits in full.

If the amount of proceeds payable to you is \$5,000 or more, a Total Control Account will usually be established in your name once your claim is approved. You will receive a personalized "draft book" and a kit that includes a Customer Agreement and gives you additional information regarding your Account. By using one of your personalized "drafts," you can draw a draft on your Total Control Account for the entire amount at any time. Information regarding the other settlement options available will also be provided.

While your money is in a Total Control Account, it is guaranteed by MetLife. You can access all or part of the insurance proceeds at any time, simply by writing one of your drafts (minimum \$250). You are not charged for drafts, there are no monthly maintenance fees, and there are no penalties for withdrawing all or part of your TCA balance. All guarantees are subject to the financial strength and claims-paying ability of MetLife.

We hope that the Total Control Account will help you rest a little easier knowing that your TCA is guaranteed, earning interest at rates responsive to current market conditions, and accessible to you when you need it, giving you time to make financial decisions that are right for you. Please read the additional information regarding the Total Control Account on the following pages.

If you have further questions about this claim, please call our toll-free Customer Service Center 1-800-638-6420.

## **Total Control Account Features**

### **The Total Control Account<sup>®</sup> (TCA) Settlement Option Provides...**

#### **INTEREST**

- Your TCA earns interest from the date it is established. MetLife sets the TCA rates weekly. Changes in the interest rate will be applied prospectively. The interest credited to your TCA will never fall below the effective annual yield guaranteed in your Customer Agreement, and will equal or exceed the rate established by at least one of the following indices: the prior week's Money Fund Report Averages<sup>™</sup>/Government 7-Day Simple Yield or the Bank Rate Monitor<sup>™</sup> National Money Market Rate Index.
- Interest is compounded daily and credited monthly to your TCA. (Generally, the interest you are paid will be subject to income tax. You should consult your own advisors about your particular tax liabilities and investment options.)

#### **IMMEDIATE ACCESS TO FUNDS AND FLEXIBILITY**

- **You can withdraw all or part of your TCA balance immediately** or at any time you wish, without penalty or loss of interest, by writing a draft to yourself. You can write drafts from a minimum amount of \$250 up to the full amount, including interest, in your TCA at any time.
- There are no limits on the number of drafts you can write each month. The drafts MetLife provides to Accountholders can be used like checks and are generally accepted by merchants and financial institutions that accept checks.
- You can name a beneficiary to receive your TCA balance in case something happens to you.
- If you do not want a TCA, you may request a check for the total benefits by writing "check" beneath your signature on the attached claim form.
- The obligation of Metropolitan Life Insurance Company (MetLife) or of the MetLife insurance company affiliate that issued the underlying policy (the "Issuing Insurance Company") to pay the total benefit or proceeds is satisfied by the delivery of your TCA draft book, and crediting the total proceeds in your TCA.

#### **NO MONTHLY MAINTENANCE FEES**

- There are no monthly maintenance fees for your TCA, and no charges for withdrawals or drafts.
- There are no monthly service or transaction charges. There is no charge for printing or reordering drafts.
- Please note: automatic electronic fund transfers, electronic bill payments, and phone payments are not available from TCA.

You may be charged a fee for special services. The fee will be withdrawn from your TCA. The current special service fees are:

- Draft copy: \$2.00
- Stop Payment: \$10.00
- Overdrawn TCA: \$15.00
- Wire Transfer: \$10.00

In accordance with your TCA Customer Agreement, special service fees are subject to change by the processing bank. MetLife may charge you a fee if you request overnight delivery service. The current fee for overnight delivery service is \$25.00.

#### **TCA SERVICES**

- MetLife sends you a quarterly statement regarding Account balances and activity.
- Statements are also sent monthly if there has been withdrawal activity in the Account.
- Dedicated Service Representatives are within easy reach to answer any questions you may have about your TCA, **including interest rates, by calling Customer Service at 1-800-638-7283. Callers with a TDD may call 1-800-229-3037.**

## **TIME TO DECIDE**

- Your rights to elect other available settlement options are preserved. As long as your TCA balance has not dropped below \$2,500, you may place some or all of your TCA balance in any other settlement option that is available to you, subject to that option's minimum dollar requirement.

Group policy settlement options include:

- A check
- A TCA
- A Guaranteed Interest Certificate (GIC) – A GIC may be available after your TCA is established. The amount applied will earn interest at a set rate for the period you select, compounded monthly. Interest penalty applies for early withdrawals.

If you transfer your TCA balance into another settlement option, bear in mind that this will be a new, separate arrangement. For more information about options available to you, call your assigned financial services representative, if any, or call 1-800-638-7283. Callers with a TDD may call 1-800-229-3037.

## **More Useful Information about the Total Control Account...**

- Unless the insured pre-selected an alternative settlement option, payment is usually made by a single check for the total proceeds under any of the following circumstances:
  - The proceeds payable are less than \$5,000;
  - The claimant resides in a foreign country; or
  - The claimant is a corporation or similar entity.

If payment may not be made through the establishment of a TCA, more information will be provided to the claimant as the claim is processed.

- TCAs which become abandoned property as defined by applicable law will be escheated to the appropriate state.
- The assets backing your TCA are maintained in the general account of MetLife or the Issuing Insurance Company. These general accounts are subject to the creditors of MetLife or the respective Issuing Insurance Company. MetLife or the Issuing Insurance Company bears the investment experience of such assets and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Regardless of the investment experience of such assets, the effective annual yield on your Account will not be less than the rate guaranteed in your Customer Agreement. Currently TCAs established from group policies have a guaranteed minimum effective annual yield of .5%. The guaranteed minimum effective annual yield may be more or less at the time your TCA is established. **You may call 1-800-638-7283 for more information on current interest rates. Callers with a TDD may call 1-800-229-3037.**
- The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. However, the entire amount of your TCA, including all interest credited to your TCA, is fully guaranteed by the financial strength and claims paying ability of MetLife or the respective Issuing Insurance Company. **FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.**
- The Issuing Insurance Company's guaranty is further backed by your respective state insurance guaranty association. Maximum limits vary from state to state and may change over time. Contact the National Organization of Life and Health Insurance Guaranty Associations ([www.NOLHGA.com](http://www.NOLHGA.com)) to learn more.

Total Control Account® is a registered service mark of Metropolitan Life Insurance Company.

## FRAUD WARNINGS

**Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.**

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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

**Arkansas, District of Columbia, Louisiana, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia:** 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.

**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.

**Delaware, Idaho, Indiana and Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York:** 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

**Oregon:** Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Texas:** 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.

**Vermont:** Fraudulent insurance act. No person shall, with intent to defraud: present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact; or present or cause to be presented any information which contains false representations as to any material fact or which conceals a material fact concerning the solicitation for sale of any insurance policy or purported insurance policy, an application for certificate of authority, or the financial condition of any insurer.

**Pennsylvania and all other states:** 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Statement of Claim for  
Accidental Dismemberment Benefits and Additional Benefits**

**Claimant's Statement** (To be Completed by the Claimant)

**Information about the Insured Employee:** (It is not necessary to complete this section if you are the claimant as well as the insured)

1. Insured Employee Name (First, Middle, Last)      2. Employer Name

3. Address

4. Marital Status

Single    Married    Widowed    Separated    Divorced

**Information about you:**

1. Your Name (First, Middle, Last)      2. Social Security Number

3. Date of Birth

4. Phone Number

Day:

Evening:

5. Address

6. Fax Number (Optional)

7. Relationship to the Insured:

Spouse    Child    Parent    Self    Other (explain)

8. When did the accident happen? Date

(Month) (Date)

at (Year)

(Hour)

{ a.m.  
p.m.

9. Where did the accident happen?

City

State

10. Give a brief description of the accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Total Control Account (TCA)**

**Total Control Account (TCA)**

Our standard payment method is in the form of a **Total Control Account**. A personalized draftbook and a kit that includes information about your TCA will be sent to you if an Account is established. Your TCA will be guaranteed by MetLife and your TCA will be accessible to you when you need it.

Name of Insured Employee \_\_\_\_\_ Insured's Employer's Name \_\_\_\_\_

**Certifications and Signature:**

By signing below, I acknowledge:

1. All information I have given is true and complete to the best of my knowledge and belief.
2. I consent to the pro rata deduction of any contributions owed by the insured from insurance proceeds paid to me.
3. I have read the applicable Fraud Warning(s) provided in this form.

**Under penalty of perjury, I certify:**

1. **That the number shown on this form is my correct taxpayer identification number; and**
2. **That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and**
3. **I am a U.S. citizen, or a U.S. resident for tax purposes.**

(Please note: You must cross out item 2 and/or item 3 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest and dividend income on your tax return; or you are not a U.S. citizen or U.S. resident for tax purposes.)

The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding.

**Please sign** below (include first and last name). If Beneficiary is a minor, the legal guardian or adult submitting this form must sign, not the minor. If no legal guardian is appointed to handle the minor's estate, a responsible adult should complete and sign the claimant statement on behalf of the minor beneficiary. If a legal guardian of the minor child's estate has been or will be appointed, the guardian must complete and sign the claimant statement. Be sure to include a copy of the court-issued guardianship papers in the claim submission to MetLife.

\_\_\_\_\_  
Claimant Signature

\_\_\_\_\_  
Date Signed






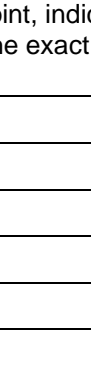





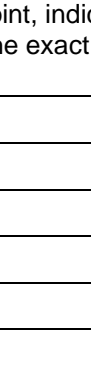





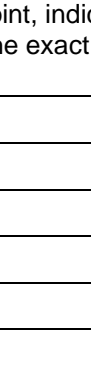


**Metropolitan Life Insurance Company**  
**Statement of Claim for**  
**Accidental Dismemberment Benefits and Additional Benefits**



Name of Insured Employee _____		Insured's Employer's Name _____	
<b>Attending Physician's Statement</b>			
1. Name of patient (First, Middle, Last)		Age	2. Date of accident causing present loss (Month, Day, Year)
3. Date first consulted on account of the injury described (Month, Day, Year)		4. Date of last treatment for this condition (Month, Day, Year)	
5. Describe the exact nature, location, and extent of all injuries sustained _____ _____			
6. Was the injury described solely responsible for the loss? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, give the particular of any contributing cause or causes. _____ _____			
7. Names of any other physicians who treated the patient for a contributory condition and the dates of their first and last treatments as reported to you. _____ _____ _____			
8. In your opinion, was the loss caused in any way by illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the date you provided treatment for the illness? _____			
9. Did the patient ever consult you before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state the dates and the ailments for which you attended, treated, or examined. _____ _____			

Please also complete the applicable section for the benefit being claimed.

<b>To be Completed Only For Limb/Digit Amputations</b>													
<p>What limb/digit was severed or amputated? _____</p> <p>State the dates on which the severance or amputation occurred. _____ _____</p> <p>State the cause of the amputation. _____ _____</p> <p>If the limb/digit was reattached, indicate date of reattachment and functional outcome. _____ _____</p>	<p>State the exact point at which the amputation was performed or the severance occurred with respect to each limb/digit lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 15%;">RIGHT</td> <td style="width: 15%;">LEFT</td> <td style="width: 15%;">RIGHT</td> <td style="width: 15%;">LEFT</td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	RIGHT	LEFT	RIGHT	LEFT								
RIGHT	LEFT	RIGHT	LEFT										
													

Signature of Attending Physician \_\_\_\_\_

Date Signed (Month, Day, Year) \_\_\_\_\_

Print Name of Attending Physician \_\_\_\_\_

Name of Facility \_\_\_\_\_

Address \_\_\_\_\_

( ) - \_\_\_\_\_  
Phone Number

Name of Insured Employee \_\_\_\_\_ Insured's Employer's Name \_\_\_\_\_

**To be Completed Only For Loss of Vision**

Has the patient had entire and irrecoverable loss of sight following the injury?

Yes  No

If yes, please answer the following:

Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

Date \_\_\_\_\_

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

Give the date and vision found on last eye examination.

Date \_\_\_\_\_

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

State the cause of loss of vision:

\_\_\_\_\_

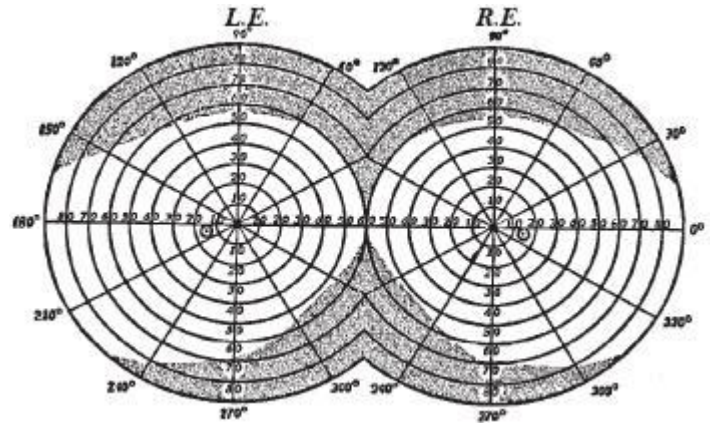
\_\_\_\_\_

\_\_\_\_\_

Indicate whether recovery or useful vision is possible by operation or treatment.

O.D.	<input type="checkbox"/> Operation	<input type="checkbox"/> Treatment
O.S.	<input type="checkbox"/> Operation	<input type="checkbox"/> Treatment

If fields of vision are contracted, show contraction on chart below.



**To be Completed Only For Burn**

Has the patient suffered third degree burns as a result of an accident?  Yes  No

Location of third degree burns.

What percentage of the body surface suffered third degree burns?

\_\_\_\_\_ %

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To be Completed Only For Rehabilitative Physical Therapy**

Did the patient suffer a loss resulting from an accidental injury?  Yes  No

Date of accidental injury: \_\_\_\_\_

Did you prescribe rehabilitative physical therapy for the patient as a consequence of the loss?  Yes  No

Date therapy prescribed: \_\_\_\_\_

\_\_\_\_\_  
Signature of Attending Physician

\_\_\_\_\_  
Date Signed (Month, Day, Year)

\_\_\_\_\_  
Print Name of Attending Physician

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Address

(\_\_\_\_\_) \_\_\_\_\_  
Phone Number

Name of Insured Employee \_\_\_\_\_ Insured's Employer's Name \_\_\_\_\_

**To be Completed Only For Paralysis**

Date you first determined paralysis was permanent, complete and irreversible, etiology of the paralysis, and method of correction and result. \_\_\_\_\_  
 Type of lesion(s) responsible \_\_\_\_\_  
 \_\_\_\_\_

a) Date \_\_\_\_\_

b) Etiology \_\_\_\_\_

Specific limb(s) paralyzed \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Location of lesion(s) responsible \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Test results which document paralysis (i.e., physical exam, EMG, nerve conduction tests) \_\_\_\_\_  
 \_\_\_\_\_

Method of correction \_\_\_\_\_  
 Functional result of correction \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**To be Completed Only For Loss of Speech**

State duration in months of patient's entire and irrecoverable loss of speech following the injury. \_\_\_\_\_  
 \_\_\_\_\_

Date you first determined speech was irrecoverably lost and the specific etiology for absence of speech (vocalization) and method and results of correction.

b) Specify basis for speech loss:

a) Date \_\_\_\_\_

Absence of vocalization structure(s)  
 Evidence of obstruction  
 Evidence of air passage defect

Description	Corrected Method
Uncorrected	

**To be Completed Only For Loss of Hearing**

State duration, in months, of patient's entire and irrecoverable loss of hearing following the injury? \_\_\_\_\_  
 \_\_\_\_\_

Date you first determined hearing was irrecoverably lost and the residual hearing (dB) uncorrected and corrected as tested by audiometer in a soundproof room.

Date the test results which allowed you to determine the hearing loss lasted consecutively for the duration indicated above.

a) Date \_\_\_\_\_

a) Date \_\_\_\_\_

b) Audiometry:	Left Ear		Right Ear	
	Uncorrected	Corrected	Uncorrected	Corrected
500 Hz	/	/	/	/
1,000 Hz	/	/	/	/
2,000 Hz	/	/	/	/
3,000 Hz	/	/	/	/

b) Audiometry:	Left Ear		Right Ear	
	Uncorrected	Corrected	Uncorrected	Corrected
500 Hz	/	/	/	/
1,000 Hz	/	/	/	/
2,000 Hz	/	/	/	/
3,000 Hz	/	/	/	/

\_\_\_\_\_  
Signature of Attending Physician

\_\_\_\_\_  
Date Signed (Month, Day, Year)

\_\_\_\_\_  
Print Name of Attending Physician

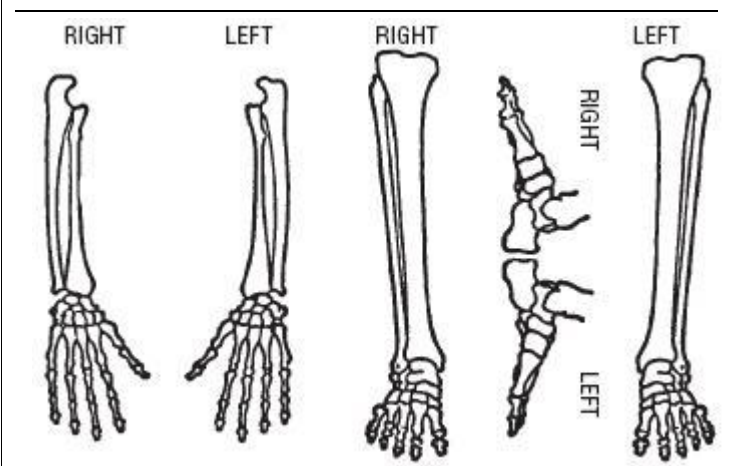
\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Address

( ) -  
\_\_\_\_\_  
Phone Number

Name of Insured Employee \_\_\_\_\_ Insured's Employer's Name \_\_\_\_\_

To be Completed Only For Brain Damage	To be Completed Only For Coma
<p>Has the patient suffered permanent and irreversible physical damage to the brain as a result of an accidental injury, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of accidental injury: _____</p> <p>Date brain damage manifested itself: _____</p> <p>Was the patient hospitalized as a result of the accidental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dates of hospitalization: _____</p> <p>State duration, in months, brain damage persisted after the injury? _____</p>	<p>Did the patient enter into a state of deep and total unconsciousness from which he/she cannot be aroused as a result of an accidental injury?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of accidental injury: _____</p> <p>Date coma began: _____</p> <p>Is the patient still in a coma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the patient is not in a coma now, date coma ended: _____</p>

To Be Completed Only For Exposure	
<p>Was the patient involved in an accident that resulted in loss of life or limb due to unavoidable exposure to the elements?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If loss of life, please explain how the exposure resulted in death.          _____          _____          _____</p> <p>If loss of limb, which limbs were lost?          _____          _____          _____</p> <p>State the dates on which amputations occurred.          _____          _____          _____</p> <p>State the cause of the amputation.          _____          _____          _____</p>	<p>If the limb was reattached, indicate date of reattachment and functional outcome.          _____          _____</p> <p>State the exact point at which the amputation was performed with respect to each limb lost. If the amputation was below the elbow or knee indicate on the chart the exact point of severance. _____</p> <p>_____</p> <p>_____</p> <div style="text-align: center;">  </div>

\_\_\_\_\_  
Signature of Attending Physician

\_\_\_\_\_  
Date Signed (Month, Day, Year)

\_\_\_\_\_  
Print Name of Attending Physician

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Address

( ) -  
\_\_\_\_\_  
Phone Number