ASSURITY AT WORK
Phone: 866-289-7337 • Fax: 402-437-4592 • PO Box 80926, Lincoln, NE 68501-0926

Application for Accident Benefits

APPLICANT PLEASE COMPLETE

1. Name of policy owner _____ Policy number(s) _____
   Current address _____ ☐ Check here if new address
   Street City State ZIP Phone number (_____) _____
   Date of birth (MM/DD/YYYY) _____
2. Name of claimant (if different from policyowner) _____ Date of birth (MM/DD/YYYY) _____
3. Occupation _____
4. Employer's name and address _____
5. Date your physician first treated you _____ Other dates of treatment _____
6. Date the accident happened (MM/DD/YYYY) _____ Time of day _____ ☐ a.m. ☐ p.m.
7. Did the accident happen at work? ☐ Yes ☐ No Please provide a copy of the accident report.

If you are applying for **Accidental Death** or **Common Carrier** benefits, please provide: 1) certified death certificate and 2) motor vehicle or policy report.

If you are applying for **Short Term Disability Rider** benefits, please answer these questions.

- On what date did you stop performing all of your employment duties?
- When did you return to or do you expect to return to some of your employment duties?
- When did you return to or do you expect to return to all of your employment duties?

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

I hereby agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

SIGNATURE OF POLICY OWNER _____ DATE _____

EMPLOYER PLEASE COMPLETE

Employer's Statement (Must be completed and signed by your **employer** for short term disability rider benefits.)

1. Date of employee's first absence due to disability — Date employee returned to work
2. Monthly earnings $ — Date hired — Date of termination/retirement (if applicable)
3. Did the accident happen at work? ☐ Yes ☐ No
4. Will you provide "light duty" work if the employee is released with restrictions? ☐ Yes ☐ No

Name of employer	Phone number ( )	
Authorized signature	Fax number ( )	
Print name	Title or position	Date

PHYSICIAN PLEASE COMPLETE

Attending Physician's Statement (Must be completed and signed by your **physician** for short term disability rider benefits.)

Diagnosis and concurrent conditions

Report of services provided (please indicate below or attach an itemized bill)

Date of service	Place of service	Description of service	Procedure Code

Is the patient still under your care for this condition? ☐ Yes ☐ No	If still disabled, estimated return to work date	
Dates the patient was continuously, totally disabled From Through	Dates the patient was partially disabled (if applicable) From Through	
Patient's hospital admission information Date Time	Patient's hospital discharge information Date Time	
Physician's signature	Phone number ( )	Fax number ( )
Physician's name (print)	Address (City, State, ZIP)	

ASSURITY AT WORK

Phone: 866-289-7337 • Fax: 402-437-4592 • PO Box 80926, Lincoln, NE 68501-0926

If you are applying for the following benefits, an itemized bill (showing date of service, diagnosis and procedure codes) must be submitted. Please check benefit(s) you are applying for:

- ☐ Ambulance (Air or Ground)
- ☐ Appliance
- ☐ Blood/Plasma/Platelets
- ☐ Emergency Dental Work
- ☐ Emergency Room Visit
- ☐ Eye Injury
- ☐ Gunshot Wound
- ☐ Lodging (lodging bill, companion name)
- ☐ Major Diagnostic Exam
- ☐ Physician's Office Visit/Urgent Care
- ☐ Prosthetics
- ☐ Transportation

If you are applying for the following benefit(s), please have your physician complete the applicable section(s) below.

Date of accident _____ Date(s) of service _____

Burns

- ☐ 2nd degree burns which cover at least 36% of the body surface
- ☐ 3rd degree burns which cover at least 1% of the body surface but less than 20% of the body surface
- ☐ 3rd degree burns which cover 20% or more of the body surface

Fractures

What is the diagnosis code? _____
What bone was fractured? _____
Was it a chip fracture? ☐ Yes ☐ No
Was it ☐ open reduction *or* ☐ closed reduction?

Knee Cartilage

What is the diagnosis code? _____
Was ☐ surgical repair done *or* ☐ exploratory arthroscopic surgery done *or* ☐ cartilage shaved?

Loss of Finger, Toe, Hand, Foot or Sight

- ☐ Both hands ☐ Both feet ☐ Sight of both eyes
- ☐ One hand ☐ One foot ☐ Sight of one eye
- ☐ Two or more fingers ☐ Two or more toes
- ☐ One finger ☐ One toe

Surgery

What is the diagnosis code? _____
What was the date of surgery? _____
Was it ☐ open abdominal *or* ☐ open thoracic?
Was it ☐ repaired surgically *or* ☐ exploratory?

Tendon/Ligament/Rotator Cuff

What is the diagnosis code? _____
What was the date of surgery? _____
Was it ☐ repaired surgically *or* ☐ exploratory?

Dislocation

What is the diagnosis code? _____
What joint was dislocated? _____
Was it ☐ open reduction *or* ☐ closed reduction?
Was anesthesia used? ☐ Yes ☐ No
Was this an incomplete dislocation? ☐ Yes ☐ No

Hospital Admission/confinement/ICU

What is the diagnosis code?
Admission date _____ Time _____
Discharge date _____ Time _____
Name of hospital _____
Address _____
City, State ZIP _____
Was insured in ICU? ☐ Yes ☐ No
If "Yes," dates in ICU: From _____ Through _____
Was insured ☐ admitted *or* ☐ in observation?

Ruptured Disc

What is the diagnosis code? _____
What disc was ruptured? _____
What was the date of surgery? _____

Lacerations

- ☐ Total of all lacerations is not more than 3 inches (7.6 cm) and repaired by stitches, staples or glue
- ☐ Total of all lacerations is greater than 3 and not more than 5 inches (7.6 to 12.5 cm) and repaired by stitches, staples or glue
- ☐ Total of all lacerations is more than 5 inches (12.5 cm) and repaired by stitches, staples or glue

Physician's signature	Phone number ( )	Fax number ( )
Physician's name (print)	Address (City, State, ZIP)	