Dismemberment Claim Form for Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

Send completed form to: Blue Shield Life, 4203 Town Center Blvd., El Dorado Hills, CA 95762, or call **(888) 800-2742** for information.

Note: Please complete the entire claim form. This form cannot be processed if information is incomplete.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Statement of claimant

First name	M.I.	Last name	Telephone number

Address	City	State	ZIP

Birth date (MMDDYYYY)	Social Security number	Age	Occupation

Date of accident	Did your accident happen on the job? ☐ Yes ☐ No	Have you been hospital confined? ☐ Yes ☐ No

Name of hospital

Address of hospital	City	State	ZIP

Date claimant entered hospital	Date released from hospital

These statements are true and complete to the best of my knowledge. I authorize any insurer, physician, or hospital to disclose any information regarding my insurance coverage or medical history. A photocopy of this form will be as valid as the original.

Signed ______________________________ Date released from hospital ____________

Statement of employer/group policyholder

Group name	Group policy number	Group effective date
Claimant's last day worked	**Date claimant was employed**	**Claimant's insurance effective date**
Basic life insurance amount $	**Amount of benefit requested** $	**Annual salary (if benefit is salary-based)** $

Is claimant's insurance still in effect? ☐ Yes ☐ No	Was claimant's insurance in effect on the day of the accident? ☐ Yes ☐ No	Is claimant still employed? ☐ Yes ☐ No

Signature

Signed ______________________________ Date ______________

Title	Telephone number

Address	City	State	ZIP

Attending physician's statement

Name of claimant	Date of birth

Please identify the loss:

Is the loss permanent and irrecoverable? ☐ Yes ☐ No	Was the loss caused by an accident? ☐ Yes ☐ No

Diagnosis (including any complications)

Objective findings

Patient's condition: ☐ Recovered ☐ Improved ☐ Retrogressed ☐ Unchanged ☐ Ambulatory ☐ Hospital confined ☐ Bed confined ☐ House confined

Date of first visit	Date of last visit

Frequency of visits
☐ Weekly ☐ Twice monthly ☐ Monthly ☐ As needed ☐ Other (specify)

When did accident happen or symptoms first appear?	Is patient able to work? ☐ Yes ☐ No
Has patient ever had the same or similar condition? ☐ Yes ☐ No If Yes, when?	Has patient been hospitalized for this condition? ☐ Yes ☐ No If Yes, when?

Name of hospital

Address of hospital	City	State	ZIP

Date patient entered hospital	Date released from hospital

Attending physician (please print)

Name	Telephone number

Address of hospital	City	State	ZIP

Specialty/degree	Date

Signature

X ______________________________