BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
ADMINISTERED BY: PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY
PO Box 34952 • Omaha, NE 68134-9832 – TEL 1-888-453-5120 • FAX 1-888-453-5127

FAMILY MATTERS NO MATTER WHAT

ACCIDENT CLAIM FORM

INSTRUCTIONS:

1. Please make sure all questions on this form are completed.
2. If we request an authorization form from you, please complete, sign and date the authorization form we've included.
3. For **Accident** claims, please attach itemized hospital bills, physician bills or medical records documenting the injuries and treatment received.
4. For **Sickness - Hospital Confinement** claims, please attach the itemized hospital bill and medical records documenting the reason for the confinement.
5. For **Health Screening or Wellness Benefit** claims, please check this box ☐ and attach the itemized bill or medical documentation showing you received a covered health screening test.
6. Please read the Fraud Notices.
7. **Please mail all correspondence and completed claim form to PO Box 34952, Omaha NE 68134-9632 or fax to 1-888-453-5127.**

Insured's full name _____ Policy/Certificate No. _____

Address _____ Daytime telephone No. _____
STREET CITY STATE ZIP CODE

☐ Check if this is a new address Insured's Social Security No. _____

Mailing address *(if different)* _____

Name and telephone number of employer _____

Claimant's *(Patient's)* full name _____ Claimant's Date of birth _____ Relationship to Insured _____

Please complete this form in full and provide the additional information asked for in the instructions box to avoid delays in the processing of your claim.

1. COMPLETE THIS SECTION IF CLAIM IS FOR ACCIDENT:

Give the date of the accident ___/___/___ Location of accident _____

Explain how the accident happened *(if due to a motor vehicle accident, attach a copy of the accident report)* _____

_____

_____

List all injuries received _____

Did the accident occur while working for pay or profit? ☐Yes ☐No

If yes, was the accident covered by any state or federal worker's compensation, employer's liability or occupational disease law?
☐Yes ☐No

Name and address of treating physician _____

_____

2. COMPLETE THIS SECTION IF FILING A CLAIM UNDER THE SICKNESS-HOSPITAL CONFINEMENT BENEFIT RIDER:

Condition claim is being filed for _____

Date symptoms first noticed ___/___/___

Names and addresses of doctors seen _____

_____

List the name and address of your regular or family physician _____

_____

3. Has patient had the same or similar condition before? ☐Yes ☐No If yes, give details _____

_____

_____

4. Has patient had other medical treatment during the past five years? ☐Yes ☐No
   If yes, describe conditions and list names and addresses of doctors consulted and dates seen _____

_____

_____

_____

5. Was patient hospitalized as a result of this claim? ☐Yes ☐No
   If yes, provide name and address of hospital _____

_____

_____

_____

Admission Date ___/___/___ Discharge Date ___/___/___

6. If your policy was issued with a Waiver of Premium Benefit Rider, please answer the following:
   Is the Payor of this policy totally or permanently disabled? ☐Yes ☐No

WARNING: 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. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

I certify that the above statements are true and correct.

Date ___/___/___ Policyowner's signature _____

For claim questions call toll free 1-888-453-5120