Dismemberment Benefit Claim Form

Please complete all relevant sections of this form. Attach medical documentation and any supporting evidence to expedite the claim process.

1. Claimant Information			
Full Name:		Date of Birth:	
Address:			
Phone Number:		Email:	
2. Policy Information			
Policy Number:		Insurer Name:	
Date Policy Commenced:		Type of Coverage:	
3. Incident Details			
Date of Accident/Incident:		Location:	
Description of the Incident:			
Body Part(s) Affected:	☐ Arm ☐ Leg ☐ Finger ☐ Toe ☐ Eye ☐ Other (specify):		
Describe the extent of dismemberment:			
4. Medical Information			
Attending Physician:		Hospital/Clinic:	
Date of Initial Treatment:		Physician Contact:	
Summary of Treatment:			
5. Declaration & Authorization			
I hereby declare that the information provided is true and complete to the best of my knowledge. I authorize the release of medical and claim-related information to the insurer for the purpose of validating this claim. Signature: _____ Date: _____			

Instructions: Attach copies of medical reports, identification, and supporting documents. Submit the completed form to your insurance provider's claims department.