

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, (888) 800-2742.

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

Important notice: 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 a state prison.

Statement of claimant

First name	M.I.	Last name	Telephone number ()	
Address		City	State	ZIP
Birth date (mo/day/year)	Social Security number		Age	Occupation
Date of accident	Did your accident happen on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was claimant's insurance in effect on the day of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is claimant still employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____