



**NORTH CAROLINA MUTUAL  
LIFE INSURANCE COMPANY**

**ACCIDENTAL DISMEMBERMENT CLAIM FORM  
LOSS OF LIMB**

Instructions:

1. Employee completes sections 1 through 20
2. Employer or Administrator completes sections 21 through 33.
3. Attending Physician completes section 34- 49.
4. Attach a police report or accident report, if available.

Return to: NCM Life Insurance Co.  
411 West Chapel Hill Street  
Durham, NC 27701  
Attn: Sharon Lee

| EMPLOYEE'S STATEMENT  |  |  |  |                              |
|---|--|--|--|------------------------------|
| 1. Name of Employee   |  | 2. Social Security Number                                  | 3. Date of Birth                         | 4. Telephone Number          |
| 5. Home Address   |  |  | 6. Employed By                           | 7. Annual Salary             |
| City  | State                                  | Zip  | 8. Occupation                            |                              |
| 9. Describe fully your various duties   |  |  |  |                              |
| 10. When did the accident happen?<br>Mo _____ Day _____ Yr _____  |  | <input type="checkbox"/> AM<br><input type="checkbox"/> PM | 11. Where did the accident happen?       |                              |
| 12. How did the accident happen?  |  |  |  |                              |
| 13. What were you doing at the time?  |  |  |  |                              |
| 14. What injury did you receive?  |  |  | 15. When did you stop working?           |                              |
| 16. Names and address of all physicians consulted<br>Name   |  | Street Address   | City, State, Zip Code                    | Date Treated                 |
|   |  |  |  |                              |
|   |  |  |  |                              |
| 17. What operation was performed?   |  |  | 18. If in a hospital, which one?         | From:<br>To:                 |
| 19. Names and addresses of witnesses to your accident   |  |  |  |                              |
| 20. I hereby authorize any hospital, physician, or other person who has attended me or examined me, to disclose when requested to do so by NCM Life Insurance Company, or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. |  |  |  |                              |
| Dated _____ 20____  |  | Signed _____<br>Employee                                   |  |                              |
| EMPLOYER'S OR ADMINISTRATOR'S STATEMENT   |  |  |  |                              |
| 21. Group Policy Number   | 22. Certificate Number (if applicable) | 23. Employee's Social Security Number                      | 24. Occupation                           | 25. Annual Salary            |
| 26. Name of Group Policyholder  |  | 27. Amount of Insurance                                    | 28. Length of Employment<br>From:<br>To: | 29. Insurance Effective Date |
| Address of Group Policyholder   |  | 30. If Cancelled, Date of Cancellation                     | 31. Date of Accident                     | 32. Last Date at Work        |
| 33. Signature of Official Representative  |  |  | Date Signed                              |                              |



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| ATTENDING PHYSICIAN'S STATEMENT  |                                      |
|--|--------------------------------------|
| 34. Patient's Name   | 35. Age                              |
| 36. On what day did you first examine and treat the patient  | Where? 37. Date of Injury            |
| 38. Had the patient previously had medical attention? If so, by whom?  |                                      |
| 39. Describe the Injury  |                                      |
|  |                                      |
| 40. What complications have arisen?  |                                      |
|  |                                      |
| 41. What operation was performed?  | Date of Surgery                      |
| 42. Name of Surgeon  |                                      |
| 43. If in hospital, which one?   | Date of Hospitalization<br>From: To: |
| 44. Was the injury described above, of itself and independent of all other causes, sufficient to require amputation?                                     |                                      |
| 45. Are you aware of patient having been medically or surgically treated at any time for any disorder, complaint or old injury affecting amputated limb? |                                      |
| 46. To your knowledge, did patient ever have any constitutional or specific disease, either hereditary or acquired? If so, what?                         |                                      |
| 47. To what other companies or associations are you reporting this injury?   |                                      |
| 48. Name   | Telephone                            |
| Address  |                                      |
| 49. Signature  | Date Signed                          |