



**NORTH CAROLINA MUTUAL  
LIFE INSURANCE COMPANY**

**ACCIDENTAL DISMEMBERMENT CLAIM FORM  
LOSS OF SIGHT**

Instructions:

1. Employee completes sections 1 through 20
2. Employer or Administrator completes sections 21 through 33.
3. Attending Physician completes section 34- 48.
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

<b>EMPLOYEE'S STATEMENT</b>				
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? Mo _____ Day _____ Yr _____		<input type="checkbox"/> AM <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 Name		Street Address	City, State, Zip Code	Date Treated
17. What operation was performed?			18. If in a hospital, which one?	From: 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 _____ Employee		
<b>EMPLOYER'S OR ADMINISTRATOR'S STATEMENT</b>				
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 From: 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	



<b>ATTENDING PHYSICIAN'S STATEMENT</b>	
34. Patient's Name	35. On what date did you first examine and treat patient? Where?
36. Had patient previously had medical attention? If so, by whom?	37. To what other companies or associations are you reporting the injury?
38. Describe condition of eye at your first visit.	
39. How was the injury received? Where?	
40. Did you find any evidence of former impairment, old injury or disease of either eye?	
41. When first examined was there any perception of light or objects in the injured eye?	Is there now, in the injured eye, any perception of light or objects?
42. What is the degree of vision in the right eye?	Left eye?
43. If the entire sight of the eye has been lost, about what date was it lost?	
44. Is loss of sight irrevocable? If yes, please explain.	If not, what measures would improve vision?
45. Did any disease or cause, other than the injury referred to, operate as a complication or contribute to the result in this case? If yes, please explain.	
46. On chart below, please indicate location of injury, adding any necessary comments.	
47. Name	Telephone
Address	
48. Signature	Date Signed

