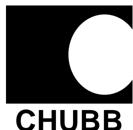

Employee Accidental Injury

Employer's Statement

(Please print – Attach separate sheet if additional space required)

POLICYHOLDER INFORMATION

Policyholder Name_____________________________ **Policy Number**_____________________________

Policyholder Address ____

INSURED INFORMATION*

Name_____________________ **Soc. Sec. No.** _____-_____-_____ **Date of Birth** ___________ **Marital Status** ______

Address____

Hire Date_______________ **Date Last Worked** ______________ **Annual Earnings** ______________

Insured's Occupation_______________________ **Nature of Duties** _____________________________

Insurance Effective Date ____________________ **Insured Class** _____________________ **Benefit Amount**__________________

Does the insured have any other accident or life insurance? _________**If yes, please list all companies, policy numbers and insurance amounts:** ____

*** PLEASE ATTACH COPY OF INSURED'S ENROLLMENT FORM, IF APPLICABLE.**

CLAIM INFORMATION

Date of accident ____________________ **Time and place accident occurred**_____________________________

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____________________________

____

Was the accident related to the insured's occupation? ______ **If so, how?** _____________________________

Was Workers' Compensation claim filed? _______**If so, please advise name and address of Workers' Comp. carrier:**__________________

____

EMPLOYER CERTIFICATION

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Authorized person) ____ **DATE** ____/____/____

NAME______________________________ **TITLE**_________________________ **PHONE NO.** _______________________