Assumption Life
Group Insurance

Accidental Dismemberment Claim Form Attending Physician's Statement

______________________ Patient's First Name

______________________ Patient's Last Name

___ / ___ / _____ Date of Birth (DD/MM/YYYY)

A) Date of Accident: (DD/MM/YYYY) ____/____/_______

B) Nature of Accident: ____

C) Was the injury self-inflicted? ☐ Yes ☐ No

D) Are there any other contributing factors to the loss? ____

E) Date of **first** treatment following accident: (DD/MM/YYYY) ____/____/_______
Date of **last** treatment following accident: (DD/MM/YYYY) ____/____/_______

F) Was the patient treated in hospital? ☐ Yes ☐ No Dates: (DD/MM/YYYY) ___ / ___ / _____ to ___ / ___ / _____
Name of hospital:______________________________ Location: ______________________

G) Surgical treatment, if any.
Date of surgery: (DD/MM/YYYY) ____/____/_______
Details:____

H) Are you aware of any other physician(s) who treated this patient due to this accident? ☐ Yes ☐ No
If yes, please give name(s) and complete address(es). ____

I) Please give details regarding the loss.

	Left	Right	Both	Date of Loss (DD/MM/YYYY)	Level of Amputation or % of Loss of Use
Hand	☐	☐	☐	___ / ___ / _____	
Foot	☐	☐	☐	___ / ___ / _____	
Arm	☐	☐	☐	___ / ___ / _____	
Leg	☐	☐	☐	___ / ___ / _____	
Other: ____________________	☐	☐	☐	___ / ___ / _____	

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 1-855-244-7011 Fax 1-855-401-9068 E-mail : lifedisability@assumption.ca

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______________________ Patient's First Name ______________________ Patient's Last Name ___ / ___ / _____ Date of birth (DD/MM/YYYY)

J) If loss of sight, please specify.

	Left Eye	Right Eye
Visual acuity		
Acuity with glasses		
Vision may be fully or partially corrected by:	☐ Glasses ☐ Surgery ☐ Treatment ☐ No method	☐ Glasses ☐ Surgery ☐ Treatment ☐ No method

K) Is the loss of use a direct result of the accident and independent of any other cause? ☐ Yes ☐ No
If no, please explain: ____
____
____
____

L) At the time of the accident, had the patient taken:
Medication ☐ Yes ☐ No Drugs ☐ Yes ☐ No Alcohol ☐ Yes ☐ No

If yes, please provide test results.

M) Comments and other pertinent information:
____
____
____
____
____
____
____
____

First Name ______________________ Last Name ______________________
Full Address ____
Telephone ______________________ Fax ______________________
☐ General Practitioner ☐ Specialist (specify) ______________ ☐ Other (specify) ______________

______________________ Signature of Attending Physician ______________________ Date (DD/MM/YYYY)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED TO COMPLETE THIS FORM.

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