



Accidental Dismemberment/Personal Loss Claim Form

Submit to:
The Business Council of NY State, Inc.
Insurance Fund
12 Corporate Woods Blvd.
Albany, NY 12211-2344
Fax: (518) 432-7033

- Employer completes Section 1
- Employee completes Section 2.
- Injured Person completes sections 3 and 4.

- Physician completes the Physician Statement on the reverse side.
- Ultra Benefit Claim Statement Sections completed as needed.
- Submit to Aetna: Claim form, Enrollment form, Attending Physician's Statement, the applicable Enhanced Personal Protection form(s) Ultra Benefits Statement.

Please print all information

1. Employer Information	Name				Fax Number ()	
	Address (street, city, state, zip code)				Daytime Telephone Number ()	
	Control Number	Suffix	Account	Plan Code	Policy Effective Date (MM/DD/YYYY)	Employee's Effective Date (MM/DD/YYYY)
	Were premiums paid up to date of accident ? <input type="checkbox"/> No <input type="checkbox"/> Yes				Rate of Basic Earnings on Date of Accident \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	
	Date employee first began work (MM/DD/YYYY)	Date employee last worked, if not working (MM/DD/YYYY)		Total amount of coverage Basic AD&PL (ADD1 or 2) \$ _____ Optional AD&PL (ADD3 or 4) \$ _____		Amount of coverage for this injury Basic AD&PL (ADD1 or 2) \$ _____ Optional AD&PL Optional AD&PL (ADD3 or 4) \$ _____
	Was the accident a result of employment? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", explain fully:					
What is the employee's current occupation?				Describe the day to day activities of the occupation or attach a copy of the job description.		
Authorized Representative Signature				Authorized Representative's Printed Name		Date (MM/DD/YYYY)

2. Employee Information	Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MM/DD/YYYY)	Social Security Number - -
	Address (street, city, state, zip code)		Work Telephone Number ()	Home Telephone Number ()

3. Injured Person's Information	Name		Relationship to Employee	Social Security Number - -
	Address (street, city, state, zip code)		Birthdate (MM/DD/YYYY)	Daytime Telephone Number ()
	Effective date of claimant's insurance	Date of Accident (MM/DD/YYYY)	Describe accident and give details of injuries sustained. (Please provide any police reports, medical records, toxicology reports and newspaper clippings related to the accident.)	
	Were you hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the name address of the hospital and the dates of confinement.			
	Please provide the hospital Admission and Discharge Summaries along with the results of any blood work performed.			
	Has a claim for benefits previously been submitted for this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the insured name and benefit claimed.			
List name(s), address(es), telephone number(s) of all attending physician(s).				
Doctor's Name		Address		Telephone Number ()
_____		_____		()
_____		_____		()

Use back if More space is needed.

4. Release to be Signed by Injured Person	To all providers of health care: You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.
	Patient's or Authorized Person's Signature _____ Date _____
	Note: If the person signing this form is the guardian or attorney-in-fact for the claimant forward a copy of the appointment papers to Aetna and send a copy to the Attending Physician.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California Residents: For your protection, California law requires notice of 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 state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida and Virginia Residents:** Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kentucky, Ohio and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Louisiana Residents and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Attention New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Physician's Statement

Patient's Full Name	Date of Accident (MM/DD/YYYY)	Place of Accident	Date first consulted for injuries resulting from this accident
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Diagnosis and complete description of injuries sustained:

Did accident result in loss of: (MM/DD/YYYY)

(A) Right hand? Date ___ / ___ / ___ Location of amputation (at, above or below wrist) _____

(B) Left hand? Date ___ / ___ / ___ Location of amputation (at, above or below wrist) _____

(C) Right foot? Date ___ / ___ / ___ Location of amputation (at, above or below ankle) _____

(D) Left foot? Date ___ / ___ / ___ Location of amputation (at, above or below ankle) _____

(E) Thumb and index finger (same hand) Date ___ / ___ / ___ Location of amputation (at, above or below metacarpophalangeals) _____

(F) Sight of right eye? Date ___ / ___ / ___ Is loss entire and irrecoverable? _____

(G) Sight of left eye? Date ___ / ___ / ___ Is loss entire and irrecoverable? _____

What was vision at last observation?

With Glasses O.D. _____ O.S. _____ Date (MM/DD/YYYY) ___ / ___ / ___

Without Glasses O.D. _____ O.S. _____ Date (MM/DD/YYYY) ___ / ___ / ___

Date corrected vision was irrecoverably reduced to 20/200 or less and the level of the vision, in the injured eye, as of that date.

O.D. _____ O.S. _____ Date (MM/DD/YYYY) ___ / ___ / ___

Vision can be restored in whole or in part by: O.D. Lenses Treatment Operations Not restorable
 O.S. Lenses Treatment Operations Not restorable

(H) Speech? Date ___ / ___ / ___ Is loss total and permanent? _____

(I) Hearing? Date ___ / ___ / ___ Is loss total and permanent? _____

(J) Quadriplegia? Date ___ / ___ / ___ Is loss entire and irrecoverable? _____

(K) Paraplegia? Date ___ / ___ / ___ Is loss entire and irrecoverable? _____

(L) Hemiplegia? Date ___ / ___ / ___ Is loss entire and irrecoverable? _____

(M) Uniplegia? Date ___ / ___ / ___ Is loss entire and irrecoverable? _____

(N) Third Degree Burn? Date ___ / ___ / ___ How much of the body received third degree burns? _____%

(O) Any other covered loss, as referenced in the AD&D section of the employer's booklet.

Was the loss sustained due solely to the above accident? Yes No

If "No", please give details of any active medical condition or disease which caused or contributed to the loss:

Was the hospitalization of the claimant due solely to the above accident? Yes No

Were the injuries or impairment caused by an accident or condition associated with employee's occupation? Yes No

If "Yes", explain fully:

Physician's Address (street, city, state, zip code)	Daytime Telephone Number () _____
Physician's Signature	Date (MM/DD/YYYY)