McNeil & Company
Dismemberment Claim Form

(No Liability is admitted by the issue of this form)

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

MAIL TO:
CLAIMS
McNeil & Company
PO Box 5670
Cortland, NY 13045
Fax: (607) 756-5967
loss_notice@mcneilandcompany.com

Any person who knowingly presents a false or fraudulent claim for payment of 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.

IMPORTANT: This form must be completed in full by claimant and the attending physician. There must have been confinement in a hospital as an inpatient due to injuries received in a covered accident in order to be eligible for benefit consideration.

Insured Information

Name of Insured: (Last Name, First Name, M.I.)		Certificate/Policy Number
Home Address: (# and Street)	(City/Town)	(State) (Zip Code)
Home Telephone	Business Telephone	Fax
Occupation:	Date of Birth:	Social Security Number

Complete if Claim is for Dependent

Name of Dependent: (Last Name, First Name, M.I.)	Relationship to Insured:	Date of Birth:

Complete for all claims

Date of Accident:	Date first treated by Physician:	Name of Physician:
Physicians Address (# and Street)	(City/Town)	(State) (Zip Code)

Describe how accident occurred:

Where did accident occur:

Describe the bodily injuries:

Did the Injury happen at work: Yes ☐ No ☐ Has a claim or will a claim be filed under worker's compensation? Yes ☐ No ☐

1	Name and address of Hospital	Date Admitted	Date Discharged
2	Name and address of Hospital	Date Admitted	Date Discharged

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. If applicable, I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative	Dated
Address:	

Authorized Policyholder Representative (please print):	Signature:	Date:

Dismemberment Claim

Name of Patient:
Last Name First Name M.I.

Date Of Birth:

Date Admitted:

Date Discharged:

Complete if Claim is for Dependent

Name of Dependent:
Last Name First Name M.I.

Relationship to Insured

Date of Birth

Attending Physician's Statement

Diagnosis and concurrent conditions(if diagnosis code other than ICDA used, provide name):

Is Condition Due to Injury or sickness arising out of patient's employment? Yes ☐ No ☐

Is Condition Due to Injury or sickness arising out of pregnancy? Yes ☐ No ☐

If "yes", approximate date pregnancy commenced:

Report of Services

(To be completed for all coverages. Itemized bill must be attached.)

Date of Services	Place of Services *	Description of surgical or medical services rendered	Procedure code **

*** Place of Services** DO- Doctors Office; H- Patients Home; IH- Inpatient Hospital; OH- Outpatient Hospital; NH- Nursing Home; OL- Other Locations

**** Procedure Codes** CPT- Current Procedural Terminology; ICDA- International Classification of Diseases

Date Symptoms first appeared or date of accident:

Date patient first consulted you for this condition:

Has patient ever had same or similar condition? Yes ☐ No ☐
If "yes", when and describe

Is patient still under your care for this condition? Yes ☐ No ☐

Does patient have other insurance coverage? Yes ☐ No ☐
If "yes", please identify

Name of Physician (print):
Last Name First Name M.I. Degree

Signature

Street Address:
and Street City/Town State Zip Code Telephone

As required by law, please provide

Social Security Number or Tax ID Number

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