

# GROUP LIFE BENEFITS CERTIFICATE OF ATTENDING PHYSICIAN DISMEMBERMENT OR LOSS

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Group Policy Number: \_\_\_\_\_

1. (a) When did the accident happen?                      Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(b) Briefly describe details of the accident. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. (a) Date of first attendance for present injury.      Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

(b) Date of most recent treatment.                      Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

3. (a) If the accident caused the loss of hand, foot fingers or toes, please indicate the point of amputation on the diagram below.

(b) Date of amputation.                                      Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_



