

statement of claim

attending physician • total vision accidental loss of sight



Group Claim Office
P.O. Box 82520 / Lincoln, NE 68501-2520
Toll free 800-487-5553

Please type or print. Patient is responsible for expenses incurred to complete this form.

patient: please complete, sign and date

Full name _____ Phone _____

Street address _____

City _____ State _____ ZIP _____

To physicians, hospitals and other institutions: I hereby authorize you to give Ameritas Life Insurance Corp. any information you have regarding my medical history and physical condition. This signed form (or a photocopy) constitutes my authorization.

I certify that the information I provided is accurate and complete to the best of my knowledge.

Signature (do not print) **X** _____ Date _____

physician: please complete, sign and date

1. Diagnosis: _____

History: (Describe how accident occurred, attach physician notes, operative reports if available)

2. Describe injury: _____

Date of injury: _____ Condition: Regressed Unimproved Improved Recovered

3. If loss of sight, complete the following:

Is the insured totally blind in the right eye? left eye? both eyes? Was the eye(s) enucleated? Yes No

Extent of visual field loss: _____

If not totally blind, vision at last observation was: With glasses: left _____ right _____ date _____

Without glasses: left _____ right _____ date _____

4. Name and addresses of other treating or referring physicians:

Can loss be improved by therapy or prosthesis? _____

If so, please explain: _____

physician who completed this form

Full name _____ Speciality _____

Street address _____

City _____ State _____ ZIP _____ Phone _____

Signature (do not print) **X** _____ Date _____