Accidental Dismemberment / Loss – Attending Physician's Statement

CLEAR FORM

1. Insured information

Clear Section

Name (First/Middle/Last):			
Policy name:			
Policy number:		Certificate number:	
Residential address:			
DOB (dd-mmm-yyyy):	Age:	Gender: ☐ Male ☐ Female	Height:

2. Physician statement

A. General statement

Clear Section

ⓘ **Please click the appropriate loss(es). The insured should review their contract to see if it covers the claimed loss.**

Incident type: ☐ Dismemberment ☐ Loss of sight ☐ Paralysis ☐ Other:

Date of accident (dd-mmm-yyyy): | Country of accident:

Nature of accident: ☐ Work-related ☐ Occupational illness ☐ Motor vehicle* ☐ Other:

Date you were first consulted concerning this accident (dd-mmm-yyyy):

Please explain in complete detail the nature of injury or loss:

If there is a loss, is it total and permanent? ☐ Yes ☐ No If "yes", specify the % of loss of use:

B. Details of loss

Clear Section

ⓘ **If the accident caused the loss of a hand, arm, foot or leg, please indicate the level of amputation. Submit a copy of all medical records, including a copy of consultation reports, progress notes, and test notes to support the claim.**

Hand: ☐ Left ☐ Right **Arm:** ☐ Left ☐ Right **Foot:** ☐ Left ☐ Right **Leg:** ☐ Left ☐ Right

Paralysis: ☐ Quadriplegia ☐ Hemiplegia ☐ Paraplegia

Sight: ☐ Left eye ☐ Right eye ☐ Both eyes Date loss of sight confirmed (dd-mmm-yyyy):

Did the loss result in the total and irrevocable loss of sight? ☐ Yes ☐ No

Eye exam results	Left eye	Right eye	Comments
Visual acuity			
Acuity with glasses			
Vision may be ☐ Fully ☐ Partially corrected by:	☐ Glasses ☐ Treatment ☐ Operation ☐ No cure	☐ Glasses ☐ Treatment ☐ Operation ☐ No cure	

Is the dismemberment or loss a direct result of the accident? ☐ Yes ☐ No
If no, please explain:

** Please provide a copy of the Accident Report and/or Police Report (if applicable).*

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C. Medical care

Clear Section

Was the claimant confined to a hospital, rehabilitation facility or nursing home as a result of this loss? ☐ Yes ☐ No

If "Yes", give name and address of hospital and dates of confinement in the table below:

Name of facility/Doctor	Address	Dates of confinement (dd-mmm-yyyy)
		From: To:
		From: To:
		From: To:
		From: To:

D. Supplementary statement

Clear Section

At the time of the accident, did the insured utilise any of the following:

Medications? ☐ Yes ☐ No	Illicit drugs? ☐ Yes ☐ No	Alcohol? ☐ Yes ☐ No
In your opinion, was any disease, infection, bodily or mental impairment an underlying cause in the loss(es)? ☐ Yes ☐ No		
In your opinion, did the loss(es) result from any self-inflicted injury or attempted self-destruction? ☐ Yes ☐ No		
Additional information:		

3. Physician information

Clear Section

Name (First/Middle/Last):	
Name of medical practice:	
Address:	
Phone:	Email:
License number:	Country of license:

Declaration

Physician declaration and signature

By signing this form, I confirm/understand that:

- *The furnishing of forms by BF&M does not constitute an admission that there is any assurance in force.*
- *The information provided above is true and complete and I confirm that I have examined the insured identified in Section 1.*
- *A photocopy of this authorisation is as valid as the original.*

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Declaration (cont'd)

Data protection declaration

By signing this form, I confirm/understand that:

- *I have obtained the insured's consent to enable the lawful transfer of their personal data to BF&M for the processing purposes described in BF&M's Privacy Policy (www.bfm.bm/privacy).*

I submit this application and fully understand that by checking the "ACCEPT TERMS" box below, I confirm that I (in my capacity as Insured or Dependent of Insured) understand and agree with the declaration set out above.

☐ **ACCEPT TERMS**

Name:	
Sign:	Date (dd-mmm-yyyy):

For BF&M official use only

Reports submitted: ☐ Accident Report ☐ Police Report (required)

Date processed: _____/_____/_____ Admin: _____ Comments: _____