

National Union Fire Insurance Company of Pittsburgh, PA
c/o Associated Underwriters, Inc.
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Gouldbusk, TX 76845
866-247-0167 Telephone
325-357-4688 Fax
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PROOF OF LOSS

NAME OF GROUP: United Truckers Association
POLICY NUMBER:
CERT:

OCCUPATIONAL ACCIDENT MEDICAL CLAIM FORM

INSTRUCTIONS:

- 1). If a claimant is treated in the hospital, please attach an itemized hospital bill.
- 2). If claimant is treated by a doctor, SECTION A is to be completed, signed and dated by the Attending Physician or attach an itemized bill.
- 3). Attach itemized bills for all medical expenses being claimed including claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.
- 4). Fax completed form to 325-357-4688.

The furnishing of this form or its acceptance by the Company must not be construed as an admission of any liability on the Company nor a waiver of any of the conditions of the insurance contract.

CLAIMANT

CLAIMANT'S FULL NAME (PLEASE PRINT)		SOCIAL SECURITY NUMBER	
STREET ADDRESS	CITY	STATE	ZIP

SECTION A – ATTENDING PHYSICIAN'S STATEMENT FOR DISABILITY

PATIENT NAME AND ADDRESS _____

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? DATE: ___/___/___

IF ACCIDENT, DESCRIBE HOW, WHEN, AND WHERE ACCIDENT OCCURRED _____

DIAGNOSIS AND CONCURRENT CONDITIONS (IF FRACTURE OR DISLOCATION, DESCRIBE NATURE AND LOCATION) _____

IS CONDITION DUE TO AN INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT YES NO

IF YES, EXPLAIN _____

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: ___/___/___

HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? YES NO

IF YES, STATE WHEN AND DESCRIBE: _____

NATURE AND DATE OF SURGICAL PROCEDURE, IF ANY (DESCRIBE FULLY) _____

WHAT OTHER SERVICE, IF ANY, DID YOU PROVIDE OR PRESCRIBE PATIENT? (PROVIDE DATES) _____

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES NO

IF "NO", GIVE DATE YOUR SERVICES TERMINATED. DATE: ___/___/___

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED? (UNABLE TO WORK) FROM: ___/___/___ TO: ___/___/___

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? FROM: ___/___/___ TO: ___/___/___

IF PERMANENT PARTIAL DISABILITY, INDICATE PERCENTAGE OF IMPAIRMENT _____

TO YOUR KNOWLEDGE, DOES PATIENT HAVE OTHER HEALTH INSURANCE OR HEALTH PLAN COVERAGE? YES NO

IF "YES" IDENTIFY. _____

ADDITIONAL ANSWERS: _____

PHYSICIAN'S NAME: _____ (PRINT) DEGREE _____ TELEPHONE () _____ - _____

SIGNATURE (ATTENDING PHYSICIAN) _____ DATE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
(OR TOWN) (OR PROVINCE)