PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®
P.O. Box 34952 • Omaha, NE 68134-9832

AGCY BEN

ACCIDENT CLAIM FORM

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

INSTRUCTIONS:
1. Please make sure all questions are complete on this form.
2. If we request an authorization form from you, please complete, sign and date the authorization forms we've included. Please keep one copy of the authorization for your records and return the other copy to us along with the completed claim form.
3. Please attach itemized hospital bills, physician bills, and other documentation of expenses.

Insured's full name _____ Policy number _____

Address _____ Daytime telephone no. _____
STREET CITY STATE ZIP CODE

☐ Check if this is a new address

Claimant's full name _____ Date of birth _____ Relation to insured _____
MO DAY YEAR

Type of coverage you are filing claim under: ☐ **Accident** ☐ **Sickness – Hospital Confinement Rider**

1. COMPLETE THIS SECTION IF CLAIM IS FOR ACCIDENT:

Explain the injuries and how the accident happened (if due to a motor vehicle accident, attach a copy of the accident report)

_____

_____

Give the date of the accident _____

Name and address of treating physician _____

2. COMPLETE THIS SECTION IF CLAIM IS FOR SICKNESS:

Condition claim is being filed for _____

Date symptoms first noticed _____

Name and address of first doctor seen _____

Name and address of other doctors seen _____

Has patient had the same or similar condition before? ☐ Yes ☐ No If yes, give details _____

3. Has patient had other medical treatment during the past five years? (Describe conditions, name of doctors consulted, provide their addresses and the dates seen.) ☐ Yes ☐ No _____

4. List the name and addresses of your regular or family physician _____

_____

5. Was patient hospitalized? ☐ Yes ☐ No _____
(NAME OF HOSPITAL) (CITY) (STATE)

Admission Date _____ Discharge Date _____

6. **Answer only if your policy has a Disability Income Rider:** Are you filing a claim for disability? ☐ Yes ☐ No If yes, a disability claim form will be sent to you to complete.

I certify that the above statements are true and correct.

Date _____ Insured's Signature _____