Click here to clear form

GROUP LIFE INSURANCE CLAIM PACKET
(Accidental Dismemberment)

SYMETRA
RETIREMENT | BENEFITS | LIFE

You Can Help Ensure a Quick Claim Decision

- ✓ All required claim forms must be signed, dated and completed fully and accurately.
- ✓ Provide all supporting documentation as required:
  - Copies of all enrollment forms completed by the member, not just the most recent form(s). This would include enrollment forms from other carriers which were completed prior to the Symetra policy.
  - Verification of Earnings as defined in your policy if claim is in excess of $100,000 and a benefit amount is based on earnings.

Policyholder's Instructions for Filing a Group Life Accidental Dismemberment Claim

Please submit the following to expedite claim review:

MEMBER or DEPENDENT CLAIM

- ☐ **Policyholder's Group Life Accidental Dismemberment Statement** fully completed by the policyholder.
- ☐ **Member's Group Life Accidental Dismemberment Statement** fully completed by the member.
- ☐ Copies of **all enrollment forms** completed by the member (including forms completed prior to the Symetra policy effective date).
- ☐ If a benefit is based on earnings and the total claim is more than $100,000, provide proof of earnings as of the period specified in your policy's Earnings definition.
- ☐ **Authorization for Release of Medical Information** fully completed by the member (or dependent if a dependent claim and the dependent is not a minor).
- ☐ **Attending Physician's Statement** – Accidental Dismemberment form completed by the member (or dependent if a dependent claim and the dependent is not a minor) and the treating physician.
- ☐ The police or accident report, newspaper articles, work injury report or similar documentation that describes the accident.
- ☐ Review the Fraud Warning Notices for your state.

Symetra reserves the right to request a verification of earnings for any claim.

Mail documents to:
Symetra Life Insurance Company
Claims Department
PO Box 1230
Enfield, CT 06083-1230

If you should need assistance in submitting the claim, please contact the Life and Absence Management Center at 1-877-377-6773 or email LADCLA@symetra.com. Additional information may be required.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650

POLICYHOLDER'S GROUP LIFE ACCIDENTAL DISMEMBERMENT STATEMENT

Group Policy Number _____

Date of dismemberment _____ Date of accident which resulted in the dismemberment _____

Policy benefit amount(s): Basic Accidental Benefit $ _____ Supplemental Accidental Benefit $ _____

Claimed dismemberment amount(s): Basic Accidental Dismemberment Benefit $ _____

Supplemental Accidental Dismemberment Benefit $ _____

A. INFORMATION ABOUT THE MEMBER

1. Member's name _____ Life Insurance Class _____
   (This information is required. Refer to your policy.)
2. Address _____
3. Social Security number _____ Date of birth _____
4. Hours worked per week _____ ☐ FT ☐ PT If benefit is based on Earnings, provide salary used to calculate benefit amount and the effective date $ _____ per ☐ hour ☐ week ☐ month ☐ year Salary effective on _____
5. Date employed _____ Occupation _____ Department/Location _____
6. Member's coverage effective on _____ Were Member premiums paid through date of dismemberment? ☐ Yes ☐ No
7. Provide date Member last worked _____ If prior to accident or dismemberment date, provide the reason Member discontinued work (vacation, illness, FMLA, layoff, etc.) _____
8. Was employment terminated prior to accident or dismemberment date stated above? ☐ Yes ☐ No
   If yes, answer the following:
   Date employment terminated _____ Was waiver of premium applied for? ☐ Yes ☐ No ☐ Unknown
   Was portability applied for? ☐ Yes ☐ No ☐ Unknown Was conversion applied for? ☐ Yes ☐ No ☐ Unknown

B. INFORMATION ABOUT THE DEPENDENT (Answer only for Dependent Dismemberment)

1. Dependent's name _____ Dependent SSN _____
2. Relationship to Member _____ Effective date of dependent coverage _____
3. Were Dependent premiums paid through date of dismemberment? ☐ Yes ☐ No

Do you recommend payment of this claim? _____ Remarks _____

I hereby certify:

- That the above member meets the eligibility requirements of the policy and is insured under the policy.
- I am not related to the member.
- I am an authorized representative of the policyholder and confirm that the above statements are true.
- I have read the attached fraud notices.

Name of Policyholder _____

Address _____

Phone _____ Fax _____ E-mail address _____

Signature _____ Print name _____

Title _____ Date _____

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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POLICYHOLDER'S FREQUENTLY ASKED QUESTIONS

SYMETRA®
RETIREMENT | BENEFITS | LIFE

Q: What happens after the claim has been submitted?
A: The claim will be assigned to a Life Claim Specialist the day it is received. A letter acknowledging receipt of the claim is sent to the policyholder and member. Within 48 hours, the claim will be reviewed. If additional information is needed to make a claim determination, it will be requested from the policyholder or the member.

Q: How long does it take for a claim to be paid?
A: Once all necessary information is obtained, payment usually takes less than five business days. Payment is sent directly to the member and written notice of the payment is sent to the policyholder.

Q: Who do I contact if I have a question about a filed claim?
A: Questions regarding claim submissions may be directed to our toll free number at 1-877-377-6773 or emailed to LADCLA@symetra.com. It is helpful if you refer to the claim number provided in the acknowledgement letter.

Q: How can I check the status of my claim?
A: Contact Symetra by phone at 1-877-377-6773 or visit www.Symetra.com/GO and log in to view your claim data if you are a registered user. If you are not a registered user, select *New User Registration* to begin the registration process.

Q: What do I do if an enrollment form is not available?
A: Proceed with submitting the claim with the documents that you have in your possession. Provide a note with the claim explaining that you have no enrollment forms and why.

Q: What if the claim is denied?
A: Symetra sends an explanation letter to the member along with instructions on how to file an appeal if the member disagrees with our decision. The policyholder will receive written notice that the claim or a benefit has been denied. If we receive additional information to support the original claim, a Life Claim Specialist will re-open the claim. If no additional information has been provided to support the original claim and a reversal of the denial, the file will be assigned to an Appeals Specialist for further review.

Symetra Life Insurance Company
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388

MEMBER'S GROUP LIFE ACCIDENTAL DISMEMBERMENT STATEMENT

INSTRUCTIONS TO THE MEMBER

- Fully complete and sign this form.
- Have the injured person or his or her legal guardian complete:
  - The Authorization for Release of Information (LB-85).
  - Part A of the Attending Physician's Statement – Accidental Dismemberment form (LD-11) and have his or her treating physician complete Part B.
- Obtain a copy of the police or accident report, newspaper articles, work injury report or similar documentation that describes the accident.
- Mail these documents to the address at the top of this claim form.

Group Policy Number _____

Claimed amount(s): Basic Accidental Dismemberment Benefit $_____

Supplemental Accidental Dismemberment Benefit $ _____

A. INFORMATION ABOUT THE MEMBER

1. Member's name _____ ☐ Male ☐ Female
2. Address _____
3. Social Security number _____ Date of birth _____
4. Daytime phone number _____ Cell phone number _____

B. INFORMATION ABOUT THE DEPENDENT (Answer only for the dismemberment of the Member's child or spouse)

1. Dependent's name _____ Date of birth _____
2. Relationship to Member _____ ☐ Spouse ☐ Child ☐ Other _____
3. If the dependent is your spouse, provide date of marriage _____
4. If the dependent is your child, answer the following:
   a. Was the dependent child attending school? ☐ Yes ☐ No
   b. If yes, ☐ full time ☐ part time Name of school _____
   c. Was the dependent child working full time? ☐ Yes ☐ No
5. If dependent was confined to a hospital since the effective date of coverage, please name the hospital and date of confinement:
   _____

C. INFORMATION ABOUT THE DISMEMBERMENT (LOSS)

1. Date of loss _____ Loss being claimed _____
2. Date of accident which resulted in the dismemberment _____ (Provide a copy of the police or accident report, newspaper articles, work injury report or similar documentation that describes the accident.)
3. Explain the loss in detail. Include where the accident occurred and the cause of the loss. Please print and attach additional pages if needed.

   _____

   _____

   _____

   _____

   _____

_____

_____

_____

_____

_____

4. Name, address and phone number of your physician(s) – please print and attach additional pages if needed.

Name	Address	Phone	Dates seen

5. Name, address and phone number of hospital where you were treated.

Hospital name Phone

Address

Date admitted Date discharged

☐ Check this box if you have been notified by the Internal Revenue Service that you are subject to backup withholding on interest and dividends, under provisions 3406(a)(1)(c) of the Internal Revenue Code.

I certify, under penalty of perjury, that the information I have provided in this Statement is true, correct, and complete to the best of my knowledge. I have read the attached fraud notices.

Signature _____ Date _____

Print name _____

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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Symetra Life Insurance Company
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY

Authorization for Release of Medical Information

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

Symetra Life Insurance Company
Claims Department
Mailing Address: PO Box 1230 | Enfield, CT 06083
Phone 1-877-377-6773 | Fax 1-877-737-3650 | TTY/TDD 1-800-833-6388

ATTENDING PHYSICIAN'S STATEMENT
Accidental Dismemberment

(Completed at Patient's Expense)

Group Policy Number _____

A. TO BE COMPLETED BY THE PATIENT

1. Full name _____
2. Date of birth _____ Social Security number _____
3. Address _____
4. Home phone number _____ Cell phone number _____

Please review and sign the Authorization for Release of Medical Information to Symetra Life Insurance Company. We will accept an authorization form preferred by your provider's office in place of the Authorization form.

Signature of patient _____ Date _____

B. TO BE COMPLETED BY THE PHYSICIAN (Please Print)

This form is used to help us determine whether the patient is eligible for an Accidental Dismemberment payment of life insurance. We need to evaluate the clinical condition of your patient. Loss means with regard to:

- hands and feet, actual severance through or above wrist or ankle joints;
- sight, speech and hearing, entire and irrecoverable loss thereof;
- thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
- movement, complete and irreversible paralysis of such limbs.

Please attach copies of chart notes, test results and consultation reports.

DIAGNOSIS

1. Was the loss solely the result of an accidental injury? ☐ Yes ☐ No
   a. If yes, on what date did the accident occur? _____
   b. If no, what disease or condition was a contributory cause? _____
   _____
2. Please give full description of the loss.
   _____
   _____
   _____
   _____
   _____
3. When did the patient first consult you for this loss? _____ Date last seen _____
4. Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe.
   _____
   _____

5. If the patient has been hospitalized, please provide:

Hospital name Phone

Address

Date admitted Date discharged

6. List other treating or referring physicians.

Name	Address	Phone	Dates seen

Please complete all that apply.

LOSS OF SIGHT

1. Did the accidental injury result in the total and irrevocable loss of sight of:
   Right eye ☐ Yes ☐ No Date of loss _____
   Left eye ☐ Yes ☐ No Date of loss _____
2. State the date you first determined that central visual acuity was irrecoverably reduced to 20/200 or less with correction _____

   Snellen notations on that date:

	Uncorrected	Corrected
ODV		
OSV		

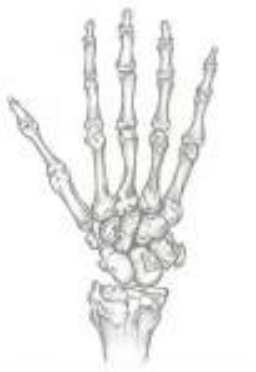
3. Can useful vision likely be restored by medication or surgery? ☐ Yes ☐ No If yes, what are the prospects?

LOSS OF LIMB(S)

1. Did the accidental injury result in a loss of limb(s)? ☐ Yes ☐ No
2. What limb(s) have been severed?

Limb	Date of severance
☐ Right hand	_____
☐ Left hand	_____
☐ Right foot	_____
☐ Left foot	_____
☐ Right thumb	_____
☐ Left thumb	_____
☐ Right index finger	_____
☐ Left index finger	_____

Please indicate exact point of severance



LOSS OF SPEECH

1. Did the accidental injury result in a loss of speech? ☐ Yes ☐ No
2. Percentage of loss _____ %
3. Will speech be recovered or partially recovered by the use of a device or rehabilitative program? ☐ Yes ☐ No
   If yes, provide details_____
   _____
   _____

LOSS OF HEARING

1. Did the accidental injury result in a loss of hearing? ☐ Yes ☐ No
2. Percentage of loss _____% right ear _____% left ear
3. Will hearing be recovered or partially recovered by the use of a device or rehabilitative program? ☐ Yes ☐ No
   If yes, provide details_____
   _____
   _____

PARALYSIS

1. Did the accidental injury result in paralysis? ☐ Yes ☐ No
2. Please select one ☐ Quadraplegic ☐ Paraplegic ☐ Triplegic ☐ Hemiplegic ☐ Uniplegic
3. Please indicate limbs affected_____
4. Did the accident result in total and irrecoverable loss of use/paralysis? ☐ Yes ☐ No
   If yes, provide details_____
   _____
   _____

I certify, under penalty of perjury, that I am a licensed physician and that the information I have given is true, correct, and complete to the best of my knowledge. I have read the attached fraud notices.

Signature _____ Date_____

Name of Physician (Print)_____

Degree/Specialty _____ Phone_____ TIN _____

Address_____

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MEMBER'S
FREQUENTLY ASKED QUESTIONS

SYMETRA®
RETIREMENT | BENEFITS | LIFE

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Q. Who do I contact if I have a question about a filed claim or would like to check the status?
A: Questions regarding claim submissions may be directed to our toll free number at 1-877-377-6773 or emailed to LADCLA@symetra.com. It is helpful if you refer to the claim number provided in the acknowledgment letter.

Q: What if my claim is denied?
A: Symetra sends an explanation letter to the member along with instructions on how to file an appeal if the member disagrees with our decision. The policyholder will receive written notice that the claim or a benefit has been denied. If we receive additional information to support the original claim, a Life Claim Specialist will re-open the claim. If no additional information has been provided to support the original claim and a reversal of the denial, the file will be assigned to an Appeals Specialist for further review.