Ullico
SOLUTIONS FOR THE UNION WORKPLACE

PROOF OF LOSS

(Accidental Dismemberment, Paralysis, Loss of Sight, Speech or Hearing)

PLEASE PRINT

Please submit this form to:
GROUP LIFE CLAIM DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Toll-free: (866) 795-0680 • Fax: (202) 962-2939

FRAUD NOTICES

Arkansas: 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.

California: For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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.

District of Columbia: 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana: 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.

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

New Mexico: 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Rhode Island: 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.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits

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TO BE COMPLETED BY POLICYHOLDER

Name of policyholder: _____

Group policy number: _____ Amount of insurance: $ _____

Name of Insured: _____ SSN: _____

This is to certify that the insured named above was eligible for benefits on the date the accident occurred. I acknowledge that I have read the fraud warning(s) above.

Signature of policyholder's representative: X _____ Date: _____

Signature and Title

TO BE COMPLETED BY INSURED

Please make certain that all pertinent questions are answered and the proper supporting documents are included before forwarding claim to avoid unnecessary delay in processing the claim.

Full name: _____ Date of birth: _____ SSN: _____

Address/P.O. Box number: _____ City: _____ State: _____ Zip: _____

Name of employer: _____

Employer address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Last day worked: _____

Date and time of accident for which claim is made: _____

Location where the accident occurred: _____

Date of first treatment by a physician: _____ Name of physician: _____

Address of physician: _____

Names and addresses of persons witnessing accident: _____

Cause and circumstances of accident. (Brief explanation of how it happened. Attach supporting documentation, police report, newspaper articles, etc.):

What bodily injuries did you sustain, caused wholly by the accident, not of previous existence and not due wholly or partly to other causes?

I hereby certify that the answers I have made to the questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud warning(s) on page 1 of this form.

Signature of Insured: X _____ Date: _____

PLEASE COMPLETE ALL PAGES

LHFM-ULL-1139 rev 03/23

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AUTHORIZATION TO RELEASE INFORMATION

1. I (the undersigned) authorize any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Insured name: _____

Date of birth: _____ SSN: _____
Last First Middle

Claimant/Insured Information to be released:

- Data or records regarding medical history, treatment, prescriptions, consultations, (including medical and psychological reports, records, charts, notes [excluding psychotherapy notes], x-rays, films or correspondence, and any medical conditions(s)):
- Any information regarding insurance coverage; and
- Accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).

Information to be released to:
The Union Labor Life Insurance Company
8403 Colesville Road, Silver Spring, MD 20910, Attn: Group Life Claim Department,

I understand the information obtained by use of this Authorization will be used by The Union Labor Life Insurance Company ("Company") to evaluate my claim for Coma/Brain Injury Benefits. The Company will only release such information:

- to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
- as otherwise may be required by law or as I may further authorize.

I further understand that refusal to sign this Authorization may result in the denial of benefits.

I understand the information used to disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.

I understand that I may revoke this Authorization in writing at any time, except to the extent:

1) the Company has taken action in reliance on this Authorization; or
2) the Company is using this Authorization in connection with a contestable claim. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

A photocopy of this Authorization is to be considered as valid as the original.

I understand I am entitled to receive a copy of this Authorization.

Legal Representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

Signature: X _____ Date: _____

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PHYSICIAN'S CERTIFICATE

Patient's name: _____ Date of birth: _____

Please provide your diagnosis: _____

Please give full description of the injury: _____

On what date did the accident occur? _____

On what date did the patient first consult you for this injury? _____

Was the patient treated by other physicians for the injury? ☐ Yes ☐ No

If so, please list the names and addresses if known: _____

_____

_____

If surgery was performed, please indicate the type of surgery performed and the date: _____

_____

Please list the name and address of the hospital where the surgery was performed if known: _____

_____

_____

Were there any complications following surgery? ☐ Yes ☐ No

If so, please explain in detail: _____

_____

_____

☐ This claim is for dismemberment. Please mark the exact point of amputation on the diagram.

☐ This claim is for paralysis. Please indicate the extent of paralysis on the diagram.

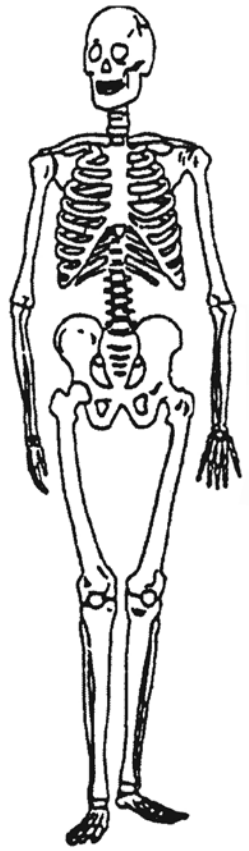
Paralysis is permanent, complete and irreversible. ☐ Yes ☐ No

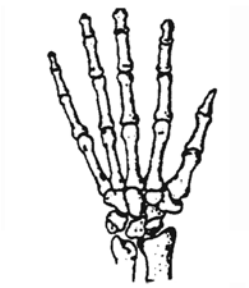
☐ This claim is for loss of use. Please identify the areas affected on the diagram.

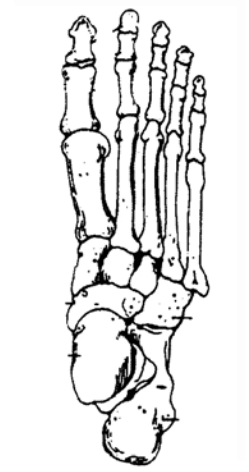
Was the dismemberment /paralysis/loss a direct result of injuries sustained in an accident, independent of all causes? ☐ Yes ☐ No

If not, please explain in detail: _____

_____







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PHYSICIAN'S CERTIFICATE Continued

If this claim is for loss of sight, what is the patient's visual acuity?_____ Is the loss total and permanent? ☐ Yes ☐ No

Is the loss due to the accident? ☐ Yes ☐ No Please explain in detail: _____

Can the vision be corrected with either surgery or lenses. ☐ Yes ☐ No If so, to what degree? _____

If this claim is for loss of speech or hearing, please attach examination and laboratory results.

At the time of the injury, had the patient been diagnosed for any specific disease, illness or old injuries? ☐ Yes ☐ No

If so, please list the diagnosis: _____

What period was the patient continuously disabled? _____

Has the patient been released to return to work? ☐ Yes ☐ No

If so, please explain in detail: _____

Would you consider the injury to be work-related? ☐ Yes ☐ No

If so, please explain in detail: _____

Have you prepared a report of this nature for any other insurance company? ☐ Yes ☐ No

If so, please provide name and address: _____

Remarks: _____

Print physician name:_____ Specialty:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Tax ID#: _____

Physician's signature: X_____ Date: _____

LHFM-ULL-1143 rev 03/23