Office of Management and Enterprise Services
Employees Group Insurance Division

Accidental Dismemberment or Loss of Sight Claim Form

Member Name: _____Member SSN or ID# : _____

Patient Name: _____Phone Number: _____

Home Address: _____ City: _____ ST: ____ ZIP: _____

This Claim is for the loss of: ____ Arm ____ Leg ____ Hand ____ Foot ____ Eye

Loss of more than one limb or eye (please specify): _____

When did accident happen: _____ Where did accident happen: _____

Describe what and how the accident happened: _____

_____

_____

_____

_____

ATTACH A COPY OF THE PHYSICIAN'S STATEMENT DESCRIBING THE INJURY AND THE TREATMENT RENDERED.

I, _____, the undersigned holder, hereby make claim under this policy for actual loss of _____. I expressly waive on behalf of myself and any person(s) who shall have or claim any interest in the proceeds, all provisions of law forbidding any physician or other person who attended or examined me from disclosing any knowledge or information thereby acquired, and I hereby expressly authorize such physician, institution, or person to make such disclosures. A photocopy of this authorization shall be considered as effective and valid as the original.

Dated this _____ Day of _____ in the year of _____. _____
Member's Signature

Return this form with original and physician statement to:
HP Administrative Services, LLC
PO Box 24110, Oklahoma City, OK 73124
1-405-416-1800 or 1-800-782-5218
TDD Line 1-405-416-1525 or 1-800-941-2160