THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Accidental Dismemberment Claim Form

Employee information

Name *(first, middle, last)*		
Address		
City	State	ZIP
Birth date *(mm/dd/yyyy)*		
Phone	Email *(required)*	

Dismemberment

Check box for type of loss *(check all that apply)*

☐ One hand ☐ Both hands ☐ Thumb and index finger of same hand ☐ One foot ☐ Both feet ☐ Speech ☐ Hearing
☐ Sight of one eye ☐ Sight of both eyes

Describe what member was doing at time of accident, how the accident happened, and how the loss occurred.

Describe injuries

Physician/hospital name		
Address		Phone
City	State	ZIP
Date of accident *(mm/dd/yyyy)*	Date of loss *(mm/dd/yyyy)*	Time of accident
Location of accident		

Authorization

I hereby affirm that I have carefully read all of the above statements; have completed this form fully and truthfully; understand that all benefits payments are subject to the terms of the Benefits Plan; and consent to receive communications via standard email to the email address provided. All statements I made on this claim form are true. I have not knowingly left out anything related to this claim.

Complete and email this form to the Board of Pensions at memberservices@pensions.org.
Questions? Call the Board at 800-PRESPLAN (800-773-7752) (TTY: 711).

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Release for medical claims

☐ I *authorize* any physician, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to the accident to the Board of Pensions of the Presbyterian Church (U.S.A.) (the Board) or its legal representative any and all such information for the purpose of evaluating a claim for benefits.

☐ I *understand* the information obtained by use of this authorization will be used by the Board to determine eligibility for benefits under the Term Life Accidental Death & Dismemberment policy. Any information obtained will not be released by the Board to any person or organization except to other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or permitted as I may further authorize:

☐ I *know* that I may request to receive a copy of this Authorization.

☐ I *agree* that a photographic copy of this Authorization shall be as valid as the original.

☐ I *agree* this Authorization shall be valid for two years from the date shown below.

☐ I *understand* that I may revoke this Authorization at any time by providing the Board with written notification as to my intent to revoke.

Employee's signature	Date *(mm/dd/yyyy)*
Print name	
Legal relationship to employee if other than employee *(if Power of Attorney, submit document.)*	

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