BF&M

Accidental Dismemberment / Loss – Claimant Statement

1. Claimant information

Name (First/Middle/Last):			
Policy name:		Policy number:	
DOB (dd-mmm-yyyy):		Certificate number:	
Residential address:			
Phone: H	W	C	Email:

2. Accident information

Date of accident or loss (dd-mmm-yyyy):	If accident, place of accident:
Nature of accident: Work related* Occupational illness Motor vehicle* Other:	
If motor vehicle accident, indicate the injured person: Driver Passenger	
Description of the accident:	
Description of loss/dismemberment:	
Was surgery required? Yes No If "yes", please provide details:	
Type of surgery:	Date of surgery (dd-mmm-yyyy):
Was hospitalisation required? Yes No If "yes", please provide details:	
Name and address of hospital:	
Dates of hospitalisation (dd-mmm-yyyy): to	
Name(s) of attending physician(s)/specialists:	

** Please provide a copy of the Accident Report, Employer's Accident Report and/or Police Report (if applicable).*

Declaration

Claimant's declaration and signature

By signing this form, I confirm/understand that:

- *The furnishing of forms by BF&M does not constitute an admission that there is any assurance in force.*
- *The information provided on this form and attachments is true and complete.*
- *For the sole purpose of determining insurability, managing files and processing this claim, I authorise BF&M Life Insurance Company Limited, and its representatives and reinsurers to collect from any hospital, physician, healthcare professional, or other person who has attended to me or examined me, any medical history, consultations, prescription or treatments, and copies of all hospital or medical records.*
- *A photocopy of this authorisation is as valid as the original.*

Data protection declaration

By signing this form, I confirm/understand that:

- *I previously provided BF&M with consent to process my personal data in accordance with BF&M's Privacy Policy (www.bfm.bm/privacy).*
- *I may withdraw my consent at any time by email to privacy@bfm.bm or by informing my agent/sales representative in writing.*
- *Such withdrawal may impact BF&M's ability to provide insurance or pay insurance claims.*

I submit this application and fully understand that by checking the "ACCEPT TERMS" box below, I confirm that I (in my capacity as Claimant) understand and agree with the declaration set out above.

☐ **ACCEPT TERMS**

Name:	
Sign:	Date (dd-mmm-yyyy):

Instructions

1. Submit completed Attending Physician's Statement Form
2. Submit completed Employer's Statement Form
3. Submit completed Claimant Statement Form (this form)
4. Submit a copy of the Accident Report, Employer's Accident Report and/or Police Report (if applicable)

Please return the fully completed forms and supporting documents to BF&M by any of these methods:

Mail: BF&M Life Insurance Company Limited, Attention: Claims Department, P.O. Box HM 1007, Hamilton HM DX, Bermuda
By hand: BF&M Life Insurance Company Limited, BF&M Insurance Building, Attention: Claims Department, 112 Pitts Bay Road, Pembroke HM 08, Bermuda
Email: lifedisabilityclaims@bfm.bm **Fax:** +1 441 296 0052

For BF&M official use only

Reports submitted: ☐ Accident Report ☐ Employer's Accident Report ☐ Police Report (required)

Policy type: ☐ Individual Insurance ☐ Group Insurance

Date processed: ____/____/____ Admin: ____________ Comments: ____________