Accidental Dismemberment / Loss – Employer Statement

CLEAR FORM

1. Employee information

Clear Section

Name (First/Middle/Last):	
DOB (dd-mmm-yyyy):	Certificate number:

2. Employer information

Clear Section

Employer name:	Policy number:
Representative (First/Middle/Last):	Title:
Phone:	Email:

3. Employment and benefit information

Clear Section

Employment date (dd-mmm-yyyy):	Effective date of coverage (dd-mmm-yyyy):
Employment status: ☐ Active employee ☐ Retiree If retiree, please provide retirement date (dd-mmm-yyyy):	
Benefit class: ☐ Employee ☐ Management ☐ Executive	Occupation:
Amount of insurance $	Date of last increase in insurance (dd-mmm-yyyy):
Annual salary on last working day (excluding bonus, overtime, and special compensation) $	

4. Claim information

Clear Section

Type of claim: ☐ Dismemberment ☐ Loss of sight ☐ Paralysis ☐ Other:	
Date of accident (dd-mmm-yyyy):	Last date worked (dd-mmm-yyyy):
Was accidental loss/dismemberment a result of a work-related accident*? ☐ Yes ☐ No If yes, is claim being made for Worker's Compensation? ☐ Yes ☐ No	
Was the employee travelling on company business at the time of the incident? ☐ Yes ☐ No	
Was the employee injured as a result of a workplace assault? ☐ Yes ☐ No	
If work-related accident, please provide details:	
Location of accident:	
Has the employee returned to work? ☐ Yes ☐ No Comments:	

** If work-related, please submit a copy of the Accident Report, Employer's Accident Report and/or Police Report (if applicable).*

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Declaration

Authorised 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 above is true and complete and confirm that the insured identified in Section 1 was eligible and insured under the provision of the Master Policy.*
- *A photocopy of this authorisation is as valid as the original.*

Data protection declaration

By signing this form, I confirm/understand that:

- *I have obtained the insured's consent to enable the lawful transfer of their personal data to BF&M for the processing purposes described in BF&M's Privacy Policy (www.bfm.bm/privacy).*

I submit this application and fully understand that by checking the "ACCEPT TERMS" box below, I confirm that I (in my capacity as Employer) 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 (this form)
3. Submit complete Employee's Statement Form
4. Submit 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)

Date processed: ____/____/____ Admin: _____ Comments: _____