

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH REQUIRED DOCUMENTATION
3. MAIL TO HSR



In addition to the claim form, the following items are required:

1. The Police Report, if the accident was reported to the police.

E-MAIL: StarrTravelClaims@hsri.com

HSR Plaza II
 4100 Medical Parkway
 Carrollton, Texas 75007
 972-512-5600, Fax 972-512-5820
 Toll Free: 866-345-0975

Policy Name: _____

Policy Number: _____

ACCIDENTAL DISMEMBERMENT CLAIM FORM
 (Please print or type except where signature is required)

Insured's Information:

1. Name of Insured: _____ Telephone Number (____) _____

2. Date of Birth: (mm/dd/yyyy) ____/____/____ 3. Social Security Number of Insured: _____

4. Address of Insured: _____

5. Did the dismemberment of the insured arise out of or in the course of his or her employment? ____ Yes ____ No

6. Employed By: _____ Annual Salary: \$ _____ Occupation: _____

Describe Fully Your Various Duties: _____

7. Date of Accident: (mm/dd/yyyy) ____/____/____ Time of Accident: _____ AM PM

8. Where did Accident happen? _____

How did Accident Happen? _____

What were you doing at the time? _____

What Injury did you receive? _____ When did you stop working? _____

9. Name and Address of All Physicians Consulted:

Name	Address	City, State, Zip	Date Treated

What Operation was Performed? _____

If in a Hospital, which one? _____

From: _____ To: _____

Names and Address of Witnesses to your Accident: _____

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 _____, to give Starr Indemnity & Liability Company 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 Starr Indemnity & Liability Company to determine eligibility for benefits under the policy. Any information obtained will not be released by Starr Indemnity & Liability Company to any person or organization except to reinsuring companies, or 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 insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative _____ Date _____

Address _____

Attending Physician's Statement:

Patient's Name _____ Date of Birth _____

Patient's Address _____

Diagnosis _____

If loss is sight, is loss in both eyes? Yes No
Is loss total and irrecoverable? Yes No
If no, visual acuity at this time _____

If loss is hearing, is loss in both ears? Yes No
Is loss total and irrecoverable? Yes No
If no, hearing at this time _____

If loss is speech, is loss total and irreversible? Yes No
If no, speech at this time _____

If loss is extremity, where is severance? _____

In your opinion, was the loss caused by an accident independent of all causes? Yes No

In your opinion, was the loss caused in any way by illness? Yes No

If yes, list dates you provided treatment for this illness: _____

Please give an account of the accident as you understand it happened: _____

Dates of Treatment for this Accident: ____/____/____, ____/____/____, ____/____/____, ____/____/____

To your knowledge, has the patient ever been treated for this same condition: Yes No

If yes, please explain

Remarks:

Name (Attending Physician) _____

Degree/ Professional Designation _____ Telephone Number: _____

Physician's Address: _____

Physician's Signature _____ Date _____

MAIL ALL NECESSARY DOCUMENTATION TO:



**HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007**