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**