NATIONWIDE LIFE INSURANCE COMPANY
NATIONWIDE MUTUAL INSURANCE COMPANY
NATIONAL CASUALTY COMPANY

ACCIDENTAL DEATH AND SPECIFIC LOSS CLAIM FILING INSTRUCTIONS

WHEN TO FILE A CLAIM
Written notice of the Claim and/or Proof of Loss restrictions apply. Please see your policy or certificate

HOW TO FILE A CLAIM – Your guide to completing this claim form
Section I The member/insured or beneficiary must answer all applicable questions
Section II Complete if the claim is related to an accidental death or dismemberment.
Section III Complete for release of medical records
Section IV Complete only for death claim
Section V County Farm Bureau Sponsor must complete this section.
Section VI If the claim is related to a loss of use of a limb, loss of sight, or loss of hearing, the attending physician must complete this section.

WHAT TO FILE WITH A CLAIM
• Copy of death certificate for death claim
• Autopsy report / coroner’s report, if performed
• Newspaper clippings, if applicable

FARM BUREAU CLAIMS
NY and PA Farm Bureau claims should be submitted to your state or county Farm Bureau Office

OH Farm Bureau claims should be submitted to:
Ohio Farm Bureau
280 N High St
PO Box 182383
Columbus, OH 43218
Attn: Member Services

WHERE TO FILE A NON-FARM BUREAU MEMBER
K&K Insurance | Specialty Benefits
PO Box 2338
Fort Wayne, IN 46801
Phone: 1-800-237-2917, option 1
ACCIDENTAL DEATH AND SPECIFIC LOSS CLAIM FORM

Please indicate type of claim:

- ☐ ACCIDENTAL DEATH CLAIM
- ☐ ACCIDENTAL DISMEMBERMENT, LOSS OF SIGHT OR LOSS OF HEARING CLAIM

### Section I: COMPLETE IN FULL

<table>
<thead>
<tr>
<th>Name of Member</th>
<th>Gender</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address of Member</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

If claim is for dependent, provide name:

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Date of Birth</th>
<th>Relationship to member</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dependent Social Security Number</th>
</tr>
</thead>
</table>

### Section II: COMPLETE IF THE CLAIM IS RELATED TO AN ACCIDENTAL DEATH OR DISMEMBERMENT.

#### Date of Accident

Where did the accident take place?

What injuries occurred?

How did the accident take place? (Explain what happened; use additional paper if necessary)

If accident involved a farm truck or a tractor or equipment being powered by a tractor, complete the following:

<table>
<thead>
<tr>
<th>Type of farm truck / tractor</th>
<th>Year and Model</th>
</tr>
</thead>
</table>

Make: __________________________

Year and Model: __________________________

Type of other equipment being powered by tractor: __________________________________________________

If hospitalized, please provide:

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hospital Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Dates Hospitalized: From / / To / /

Name and address of doctors providing services:

<table>
<thead>
<tr>
<th>Doctor Name</th>
<th>Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Doctor Name</th>
<th>Address</th>
</tr>
</thead>
</table>

### Section III: COMPLETE FOR RELEASE OF MEDICAL RECORDS

I hereby authorize and request any hospital where I have been a patient and any physician or surgeon providing services to me, to provide Nationwide Insurance or its representative, all medical information to complete the processing of this claim.

I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available regarding either: (a) benefits for which either I, or the minor child for whom I am either parent or guardian, may be entitled to for this claim, or (b) the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or the minor child for whom I am the parent or guardian; to provide Nationwide Insurance, Columbus Ohio, or its legal representatives, any and all such information. I AGREE that a photo copy of this Authorization will be valid as the original. This authorization will remain valid for the term of coverage of the policy.

Signature of Claimant: __________________________ Date (mm/dd/yyyy)

Phone: (_________)

CLAIMANT (PARENT, IF CLAIM IS FOR A MINOR)
**Section IV: COMPLETE FOR DEATH CLAIM ONLY**

Date of Death (mm/dd/yyyy) _____________________  Time ____________________ AM  PM  

Are you making this claim as the Beneficiary?  YES  NO  
If yes, my relationship to the Member/Insured is: ____________________________________________  

Are you making this claim as the Administrator, Guardian or Executor?  YES  NO  
If yes, provide appropriate proof ______________________________________________________  

The foregoing statements are true and complete to the best of my knowledge and belief. I understand forms furnished by the Company do not constitute an admission that there is any insurance in force. I agree to furnish statements by physicians who attended or treated the deceased, and all other documents called for by the Company as may be applicable to this claim and further agree that such statements or documents shall constitute and be a part of the Proof of Death.  

Signature of Claimant/Executor ________________________________________________  Date______________  

Name of Beneficiary (Print) ________________________________________________  Relationship _____________________  

Social Security, Trust or Estate Number ______________________________________  Date of Birth ____________________  

Signature of Claimant/Executor ________________________________________________  Date______________  

Name of Beneficiary (Print) ________________________________________________  Relationship _____________________  

Social Security, Trust or Estate Number ______________________________________  Date of Birth ____________________  

**Section V: FARM BUREAU CERTIFICATION FOR ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT OR HEARING**

This certifies that ____________________________________ was a Member of the ____________________________ County Farm Bureau on the date of the above described accident.  

OHIO ONLY: After making a personal check at the accident scene, I have found the Ohio Farm Bureau Tractor Safety Sticker   
Was   Was Not in place on the tractor at the time of the accident. Attached is a copy of the motor vehicle accident report indicating the insured   Was   Was Not wearing an approved seatbelt or child restraint system at the time of the accident.  

County Farm Bureau Signature ______________________________________________________  Date (mm/dd/yyyy)  

By  ____________________________  Title _________________________________  

**Section VI: ACCIDENTAL DISMEMBERMENT (Loss of Limb), LOSS OF SIGHT OR LOSS OF HEARING CLAIM**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN – Only Complete Portion of the Form that applied to Loss Incurred  

Patient’s Name ________________________________________________  Age  

☐ LOSS OF LIMB – You must submit medical records to support claim  

Date of Loss (mm/dd/yyyy)  

Date first treated by you (mm/dd/yyyy)  

Please indicate below by checking the applicable box.  

<table>
<thead>
<tr>
<th>Right Hand</th>
<th>Above Wrist</th>
<th>Below Wrist</th>
<th>Left Hand</th>
<th>Above Wrist</th>
<th>Below Wrist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Arm</td>
<td>Above Elbow</td>
<td>Below Elbow</td>
<td>Left Arm</td>
<td>Above Elbow</td>
<td>Below Elbow</td>
</tr>
<tr>
<td>Right Foot</td>
<td>Above Ankle</td>
<td>Below Ankle</td>
<td>Left Foot</td>
<td>Above Ankle</td>
<td>Below Ankle</td>
</tr>
<tr>
<td>Right Leg</td>
<td>Above Knee</td>
<td>Below Knee</td>
<td>Left Leg</td>
<td>Above Knee</td>
<td>Below Knee</td>
</tr>
</tbody>
</table>

☐ Right Thumb and Forefinger  

☐ Left Thumb and Forefinger  

NW Death and Spec Loss Claim Form (3-15)
# ACCIDENTAL DEATH AND SPECIFIC LOSS CLAIM FORM

## LOSS OF SIGHT

- **Please use Snellen notation or its equivalent** – You must provide diagnosis and enclose medical records regarding existing eye condition.

<table>
<thead>
<tr>
<th>Did insured lose sight as a result of said accident?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record of Vision</td>
<td>Uncorrected</td>
<td>Corrected</td>
</tr>
<tr>
<td>Date of first observation (mm/dd/yyyy)</td>
<td>R.E.</td>
<td>L.E.</td>
</tr>
<tr>
<td>Date of last observation (mm/dd/yyyy)</td>
<td>R.E.</td>
<td>L.E.</td>
</tr>
<tr>
<td>From what date was vision recorded in question above (mm/dd/yyyy)?</td>
<td>If totally blind, provide date this occurred (mm/dd/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Right Eye</td>
<td>Left Eye</td>
<td>Right Eye</td>
</tr>
<tr>
<td>If eye has been enucleated, provide date (mm/dd/yyyy)</td>
<td>In your opinion, can vision be improved by treatment, operation or lenses?</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

- **Give diagnosis and brief description of the existing eye condition.**

- **Is loss of sight irrecoverable?** ☐ Yes | ☐ No | State your recommendations:

- **Was there any disease or condition prior to the date of the accident, which might have served as a contributory cause?** | ☐ Yes | ☐ No | If Yes, supply medical records.

## LOSS OF HEARING

- **You must provide a copy of the following:** Measurement of pure tone air-conduction & bone conduction thresholds, speech reception threshold, discrimination score, tympanometry, acoustic reflexes, acoustic reflex decay and any medical records pertaining to this condition.

| Attending Physician Name | | Date (mm/dd/yyyy) |
|--------------------------|-----------------|
| | | |
| | | |

- **Physician Signature** | Date (mm/dd/yyyy) |

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

- **If another physician treated the insured for any contributory condition that existed prior to the accident, please provide the name and address of the other attending physician.**

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Dates treated if Known (mm/dd/yyyy)</th>
<th>Gaynor ________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

- **If treated at a hospital, provide name of institution with dates of admission and dates of discharge for this loss**

<table>
<thead>
<tr>
<th>Institution Name</th>
<th>Date Admitted (mm/dd/yyyy)</th>
<th>Date Discharged (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

---

NW Death and Spec Loss Claim Form (3-15)
State Fraud Notices

(New York) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(Alabama) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

(Alaska) A person who knowingly and with intent to injury, defraud, or deceive an insurance company files a claim containing, false, incomplete, or misleading information may be prosecuted under state law.

(Arkansas) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Arizona) For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

(California) For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Colorado) It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

(District of Columbia) WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny benefits, if false information materially related to a claim was provided by the applicant.

(Delaware) Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

(Florida) Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

(Idaho) Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

(Indiana) A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

(Kentucky) Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
(Louisiana) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Maine) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

(Maryland) Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Minnesota) A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

(New Hampshire) Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

(New Jersey) Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

(New Mexico) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

(Ohio) Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

(Oklahoma) WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

(Pennsylvania) Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Rhode Island) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Texas) Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

(Virginia) It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

(Washington) Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

(West Virginia) Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.