

**Oklahoma State and Education Employees Group Insurance Board  
Accidental Dismemberment or Loss of Sight Claim Form**

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

This Claim is for the loss of:   \_\_\_ Arm   \_\_\_ Leg   \_\_\_ Hand   \_\_\_ Foot   \_\_\_ Eye

Loss of more than one limb or eye (please specify): \_\_\_\_\_

When did accident happen: \_\_\_\_\_ Where did accident happen: \_\_\_\_\_

Describe what and how the accident happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ATTACH A COPY OF THE PHYSICIAN'S STATEMENT DESCRIBING THE INJURY  
AND THE TREATMENT RENDERED.**

**I, \_\_\_\_\_, the undersigned holder, hereby make claim under this policy for actual loss of \_\_\_\_\_. I expressly waive on behalf of myself and any person(s) who shall have or claim any interest in the proceeds, all provisions of law forbidding any physician or other person who attended or examined me from disclosing any knowledge or information thereby acquired, and I hereby expressly authorize such physician, institution, or person to make such disclosures. A photocopy of this authorization shall be considered as effective and valid as the original.**

Dated this \_\_\_\_\_ Day of \_\_\_\_\_ in the year of \_\_\_\_\_. \_\_\_\_\_  
Member's Signature

**Return this form with original and physician statement to:  
EDS Administrative Services, LLC  
PO Box 24110, Oklahoma City, OK 73124  
1-405-416-1800 or 1-800-782-5218  
TDD Line 1-405-416-1525 or 1-800-941-2160**