

# PROOF OF LOSS

This **Proof of Loss** form and related documents should be submitted to us within 90 days of first receiving treatment for an **Accident or Injury** as defined in your **Policy** or Certificate of Insurance. Please send all required documents to: **Security National Life Insurance Company, O.R.I. Claims, P.O. Box 57007, Salt Lake City, UT 84157-0007.**

**FRAUD STATEMENT:** For your protection, please be advised of the following: Any person, who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or insurance 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 the person to criminal and civil penalties.

## PART I GENERAL INFORMATION

- 1 **Name of Injured Person:** \_\_\_\_\_  
(or authorized representative)
- 2 **E-Mail Address of Injured Person:** \_\_\_\_\_  
(or authorized representative)
- 3 **Phone Number of Injured Person:** (\_\_\_\_) \_\_\_\_\_  
(or authorized representative)
- 4 **Policy or Certificate Number:** \_\_\_\_\_  
(This number is printed on the face page of your Policy or Certificate of Insurance)
- 5 **Name and Address of Your Health Insurance:**
- Name:** \_\_\_\_\_
- Address:** \_\_\_\_\_
- Phone:** (\_\_\_\_) \_\_\_\_\_
- Policy Number:** \_\_\_\_\_
- Type of Health Insurance:** Group \_\_\_ Individual \_\_\_ Other \_\_\_ I have no health insurance \_\_\_

## PART II GENERAL ACCIDENT INFORMATION

- 1 **Brief Description of Accident (include DATE, TIME and PLACE):**
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 2 **Are there Known Witness(es) to the Accident?** Yes \_\_\_ No \_\_\_
- Name:** \_\_\_\_\_
- Phone:** (\_\_\_\_) \_\_\_\_\_
- Name:** \_\_\_\_\_
- Phone:** (\_\_\_\_) \_\_\_\_\_

\*A written witness statement may be required.

**PART III  
AUTHORIZATION TO RELEASE CLAIMS-RELATED INFORMATION**

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined me (the claimant) to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature X \_\_\_\_\_ DATE \_\_\_\_\_

**PART IV  
REQUIRED SUPPORTING DOCUMENTATION**

**1 Proving your accident is covered:**

A. Statement of Attending Physician: You must obtain from the physician or facility that treated you for an accident or injury a statement attesting to the cause of your injury, as reasonably demonstrated by the totality of circumstances at the time of treatment. You may use the form provided below (“**Statement of Attending Physician**”), or your attending physician may provide the same or substantially similar information in an alternative format.

B. Accident Documentation: You must provide to us a copy of any available official record, report, description or eye witness account of your accident. Examples are provided at [www.GetORI.com](http://www.GetORI.com) on the CLAIMS page under “TIPS FOR SPEEDY CLAIMS PROCESSING AND PAYMENT.”

**2 Proving incurred expenses:**

A. Health Plan EOBs: If you are enrolled in a health plan or otherwise have health insurance coverage, you must provide to us copies of all relevant Explanations of Benefits (“EOBs”) or other evidence of benefit determinations. The EOB should plainly show the outcome of the benefit determination and identify any amounts that are your responsibility to pay, such as outstanding deductibles, co-insurance amounts, and specific co-payments.

B. Medical and Ambulance Bills: If you do not have any other coverage, you must provide to us copies of all accident-related medical charges, invoices or bills.

**Statement of Attending Physician**

Dear Physician or Medical Facility Representative:

Outdoor Recreation Insurance (“O.R.I.”) provides reimbursement benefits for medical and ambulance expenses resulting from *specifically covered injuries and activities*. Your patient (the “Claimant”) has reasonable obligations related to Proof of Loss. Please take a few moments to assist your patient by providing the following information:

**To the best of my knowledge and based upon the totality of circumstances related to the treatment of the Claimant:**

**1. Accidental Bodily Injury: The Claimant suffered an accidental bodily injury at an identifiable time and place, which injury reasonably required immediate medical attention:**

Yes: \_\_\_\_\_ No \_\_\_\_\_

Additional Comments?

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**2. Apparent Cause of Injury: The Claimant suffered an accidental bodily injury while:**

Skiing: \_\_\_\_\_ Climbing or mountaineering: \_\_\_\_\_ Kayaking: \_\_\_\_\_

Snowboarding: \_\_\_\_\_ Trail Running: \_\_\_\_\_ Rafting: \_\_\_\_\_

Snowshoeing: \_\_\_\_\_ Hiking or Trekking: \_\_\_\_\_ Canoeing: \_\_\_\_\_

Additional Comments?

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**3. Health Insurance:**

The Claimant is covered under a health plan or health insurance policy: Yes \_\_\_\_\_ No \_\_\_\_\_

**4. Signature of attending physician or medical facility representative:**

s/ \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

[Please print name above]