



**WSA**  
Fraternal Life

# Fraternal, Operation/Dismemberment Claim

Return by mail to: PO Box 351920, Westminster, CO 80035-1920  
Or Via Fax to: 303-451-5112

Member's Name: \_\_\_\_\_ Certificate Number: \_\_\_\_\_ Lodge Number: \_\_\_\_\_  
Address: \_\_\_\_\_

## Section A:

In lieu of completing the fields below, a copy of a bill and/or records providing the information necessary to determine days of disability and/or surgery performed is attached.

**NOTE: If these documents are attached and provide adequate information to complete a claim then completion of the fields below is not necessary and a physician's signature will not be required.**

## Section B:

In lieu of presenting a copy of a bill and/or records detailing the procedure and/or disability for which this claim is presented, please have your physician complete the applicable fields below:

1. Diagnosis: \_\_\_\_\_
2. When first disabled? \_\_\_\_\_
3. Dates of patient's office visits: \_\_\_\_\_
4. Patient hospitalized at: \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_
5. Operation performed, if any: \_\_\_\_\_
6. Disability Information: \_\_\_\_\_
  - A. Totally disabled from performing any kind of activity from \_\_\_\_\_
  - B. Patient partially disabled and was able to resume some activity on \_\_\_\_\_
7. Remarks: \_\_\_\_\_

## Section C (Physician Certification):

I hereby certify that the foregoing statements and answers are absolutely true and correct, without evasion or reservation, and are made subsequent to a thorough examination of the claimant by me.

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

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_

Name of Physician: \_\_\_\_\_ (Print) Signed: \_\_\_\_\_

Office Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

### For WSA Staff Use Only:

Fraternal Benefit at \$1.00/day from \_\_\_\_\_, 20 \_\_\_\_ to \_\_\_\_\_, 20 \_\_\_\_ \$ \_\_\_\_\_  
 Fraternal Benefit at \$.50/day from \_\_\_\_\_, 20 \_\_\_\_ to \_\_\_\_\_, 20 \_\_\_\_ \$ \_\_\_\_\_  
 Operation or dismemberment for \_\_\_\_\_  
 Total payment approved by WSA on \_\_\_\_\_, 20 \_\_\_\_ Check number \_\_\_\_\_ \$ \_\_\_\_\_