



**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: \_\_\_\_\_

**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 \_\_\_\_\_ \$ \_\_\_\_\_

### Physician's or Surgeon's Report

1. Patient's Name: \_\_\_\_\_
2. Diagnosis: \_\_\_\_\_
3. If disease, state whether acute, recurrent or chronic and what complications, if any: \_\_\_\_\_
4. When first disabled? \_\_\_\_\_
5. Dates of patient's office visits: \_\_\_\_\_
6. Patient hospitalized at: \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_
7. Operation performed, if any: \_\_\_\_\_
8. Prognosis: \_\_\_\_\_
9. Disability Information: \_\_\_\_\_
  - A. Totally disabled from performing any kind of activity from \_\_\_\_\_
  - B. Patient partially disabled and was able to resume some activity on \_\_\_\_\_
10. Seen in consultation by Dr.(s): \_\_\_\_\_
11. Remarks: \_\_\_\_\_

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

Graduate of \_\_\_\_\_ (Medical School) Year \_\_\_\_\_