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## Application for Disability for Loss of Eye or Eyesight

*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.*

Name \_\_\_\_\_ Lodge # \_\_\_\_\_

Male      Female      Date of Birth \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_

Signature of Insured \_\_\_\_\_

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### *Office Use Only*

Approved \_\_\_\_\_

Disapproved \_\_\_\_\_

# OPHTHALMOLOGICAL EXAMINATION

Name of Claimant \_\_\_\_\_ Date of Examination \_\_\_\_\_  
Address \_\_\_\_\_

## PAST HISTORY

Does the claimant have or has he/she ever had tuberculosis, diabetes, Bright's disease, syphilis, or hypertension?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_  
Duration of disease and present complaints \_\_\_\_\_

Eye disease and duration \_\_\_\_\_

Date of injury or disease \_\_\_\_\_

Previous history \_\_\_\_\_

Was the claimant at the time of injury under the influence of liquor, narcotics or tranquilizers? Yes \_\_\_\_\_ No \_\_\_\_\_

What other sickness or injury has contributed toward present injury or inflammation of eye? \_\_\_\_\_

## EXAMINATION AND FINDINGS

1. **VISION:**
  - a) Visual acuity measurement  
OD 20/\_\_\_\_\_  
OS 20/\_\_\_\_\_
  - b) Legally Blind  
Yes \_\_\_\_\_  
No \_\_\_\_\_
  - c) Totally Blind  
Yes \_\_\_\_\_  
No \_\_\_\_\_
2. **CORNEA:**
  - a) Shape \_\_\_\_\_
  - b) Smoothness \_\_\_\_\_
  - c) Transparency \_\_\_\_\_
3. Depth and contents of interior chamber, if any \_\_\_\_\_
4. **PUPIL:**
  - a) Size \_\_\_\_\_
  - b) Shape \_\_\_\_\_
  - c) Reaction of light and accommodation \_\_\_\_\_
5. Lens transparency \_\_\_\_\_
6. Vitreous transparency \_\_\_\_\_
7. Funds lesions, if any \_\_\_\_\_
8. Intraocular tension \_\_\_\_\_
9. Additional facts and remarks, if any \_\_\_\_\_
10. In your professional judgment, is this patient disabled based on their vision? Yes \_\_\_\_\_ No \_\_\_\_\_

I hereby certify that my answers to the foregoing questions are correct and true to the best of my knowledge and belief without any evasion or reservations.

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Doctor's Address \_\_\_\_\_