CHUBB GROUP OF INSURANCE COMPANIES

202 Hall's Mill Road, Whitehouse Station, NJ 08889

Telephone 1-800-437-5114
Fax: (908)572-4036

CLAIM INFORMATION

HOW TO FILE A CLAIM

In the event of a claim, written or verbal notice must be provided as soon as reasonably possible.

IF YOU HAVE ANY CLAIM RELATED QUESTIONS, PLEASE CALL THE CLAIMS SERVICE CENTER AT
1-800-CLAIMS-0 (1-800-252-4670)
(757) 222-4232

For Additional Claims Forms and Information:
You can go to our website (www.chubb.com), click on Report a Loss, select Accident, Benefits and Life claims, select the appropriate form, print out the claim form, fill out and mail.

- You can file a claim by mail or fax.

Mailing Address: CHUBB GROUP OF INSURANCE COMPANIES
CLAIMS SERVICE CENTER
600 INDEPENDENCE PARKWAY
P.O. BOX 4700
CHESAPEAKE, VA 23327-4700

Fax Number: Fax Number 1-800-300-2538

- Complete all items on the required claim form.
- Attach all appropriate documents (as applicable):

Accidental Injury Claim

Claimant's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ **Soc. Sec. No.** _____-_____-_____ **Date of Birth** ___/____/____ **Marital Status** ____

Insured's Address _____ **Phone No. (H)**_____

_____ **Phone No. (W)**_____

Name and address of employer _____

Policy Number (Required)_____ **Insured's Occupation** _____

Did the insured have any other insurance ? _____**If yes, please list all companies, type of insurance, policy numbers and insurance amounts:**_____

_____

CLAIM INFORMATION

Date of accident _____/_____/_____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Please describe the nature of Insured's injuries:_____

Please list the names and addresses of all treating physicians and hospitals:_____

_____

_____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** _____

CLAIMANT INFORMATION (If different than "Insured Information" above)

Claimant's Name_____ **Age**_____ **Relationship to Insured**_____

Claimant's Address_____ **Phone No. (H)** _____

_____ **Phone No. (W)**_____

In what capacity are you making this claim? _____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.
I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.
SIGNED (Claimant or authorized person) _____ **DATE** ____/____/____

Accidental Injury Claim

Attending Physician's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ **S. S No.** _____-_____-_____ **Date of Birth** ____/____/___ **Marital Status** _____

Insured's Address_____ **Phone No. (H)**_____

_____ ___ **Phone No. (W)**_____

Name and address of employer

_____

Policy Number (Required)_____ **Insured's Occupation** _____

CLAIM INFORMATION

Date of accident: ____/ ____/____ **Date of first treatment:** _____/_____/_____

Please describe in detail the nature of the Insured's injuries, including all applicable ICD-9-CM codes:

_____ _____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Was the Insured hospitalized? _____ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**

_____

_____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____

If yes, please describe: _____

_____

Were any surgical procedures performed? _____ **If yes, please list all procedures, including applicable CPT4 codes and dates performed:**

_____

_____

What are the Insured's current subjective symptoms?

_____

_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)?

_____

_____

Dates of total disability:

From: ___/_____/___ **through:** ____/____/____

Dates of partial disability:

From: ___/_____/____ **through:** _____/_____/_____

Date Insured able to return to work: _____/_____/_____

Was the Insured seen by any other physician? _____ **If yes, please list the names and addresses of all other physicians:**

_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____ **Phone No.** _____

Address: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____ **DATE** ____/____/____

Accidental Loss of Life

Claimant's Statement

INSURED INFORMATION (Please print – Attach separate sheet if additional space required)

Insured's Name_____ **Soc. Sec. No.** _____-_____-_____ **Date of Birth** ___/____/____
Marital Status _____

Insured's address_____

Name and address of last employer _____

Policy Number (Required)_____ **Insured's Occupation (at time of death)** _____

Did the insured have any other accident or life insurance? _____ **If yes, please list all companies, policy numbers and insurance amounts:**_____

CLAIM INFORMATION

Date of accident _____/_____/_____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed):
_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Please describe the cause of the Insured's death: _____

Please list the names and addresses of all treating physicians and hospitals:_____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** _____

Was an autopsy performed?_____ **If yes, please provide name and address of Medical Examiner**_____
_____

Was a coroner's inquest held? _____**If yes, what was the determination?**_____

CLAIMANT INFORMATION

Claimant's Name_____ **Age**_____ **Relationship to Insured**_____

Claimant's Address_____
Phone No. (H)_____ **Phone No. (W)**_____

In what capacity are you making this claim? _____ **Beneficiary** _____ **Executor*** _____ **Administrator*** _____ **Guardian*** _____**Trustee*** _____**Assignee***

***Please provide a certified copy of all documents supporting your authority (e.g., Letters Testamentary, Letters of Administration, etc.)**

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.
SIGNED (Claimant or authorized person) _____ **DATE** ____/____/____

Employee Accidental Death

Employer's Statement

(Please print – Attach separate sheet if additional space required)

POLICYHOLDER INFORMATION

Policyholder Name_____ **Policy Number**_____

Policyholder Address _____

INSURED INFORMATION*

Name_____ **Soc. Sec. No.** _____-_____-_____ **Date of Birth** _____ **Marital Status** _____

Address_____

Hire Date_____ **Date Last Worked** _____ **Annual Earnings** _____

Insured's Occupation_____ **Nature of Duties** _____

Insurance Effective Date _____ **Insured Class** _____ **Benefit Amount**_____

Did the insured have any other accident or life insurance? _____**If yes, please list all companies, policy numbers and insurance amounts:** _____

*** PLEASE ATTACH COPY OF INSURED'S ENROLLMENT FORM, IF APPLICABLE.**

CLAIM INFORMATION

Date of accident _____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____ ____

_____

Was the accident related to the insured's occupation? _____ **If so, how?**

_____

Was Workers' Compensation claim filed? _____**If so, please advise name and address of Workers' Comp. carrier:**

_____

_____

BENEFICIARY INFORMATION*

Beneficiary's Name_____ **Age**_____ **Relationship to Insured**_____

Beneficiary's Address___ _____ _____**Phone No. (H)**_____

_____**Phone No.(W)**_____

*** PLEASE ATTACH ORIGINAL SIGNED BENEFICIARY DESIGNATION CARD**

EMPLOYER CERTIFICATION

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Authorized person) _____ **DATE** ___/____/____

NAME_____ **TITLE**_____ **PHONE NO.**

_____