CHUBB

Accidental Death Claim Form

IMPORTANT NOTICE: Written notice of claim must be provided within 90 days of the loss. Written proof of loss must be provided within 90 days after the date of loss. If it cannot be provided within that time period, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted more than one year from the date it was otherwise required.

Please mail your completed Claim Form along with the items listed below to:

Chubb USA
PO Box 5124
Scranton, PA 18505-0556

800.336.0627 Inside USA
302.476.6194 Outside USA
ChubbAandHClaims@Chubb.com

In addition to the Claim Form, the following items are required:

1. A Certified Copy of the final death certificate;
2. The company's enrollment benefit form and Beneficiary Designation;
3. Confirmation of employee's Principal Sum and current premium payment;
4. The Police Report, any Autopsy Report, and any newspaper clippings;
5. If Business Travel, a copy of the employee's itinerary prior to the accident, purpose of trip, destination to and from trip, and confirmation that trip was authorized by the company.

Policyholder Name: Policy Number(s):

Facts Concerning Insured

Full Name: SSN:

Home Address:

Date of Birth: Place of Birth:

Date of Death: Occupation:

Name of Employer:

Employer Address:

Beneficiary

Name: Date of Birth:

Relationship to Deceased: SSN:

Address: Phone:

Statements Regarding the Accident

Date of Accident: Place:

State specifically how accident happened:

Did the accident occur in the course or during the deceased's employment? ☐ Yes ☐ No

If yes, has there been, or will there be, a claim filed for Workers' Compensation? ☐ Yes ☐ No

Name of Workers' Compensation Carrier:

Address:

To Be Completed if Death Resulted from Motor Vehicle Accident

Type of Vehicle: Registered Owner:

Was the deceased the driver? ☐ Yes ☐ No

Use of vehicle: ☐ Business ☐ Pleasure ☐ Business and Pleasure

Name of law enforcement agency investigating accident:

Address:

To Be Completed on All Claims

Was an inquest held? ☐ Yes ☐ No

If yes, please complete the following and attach a copy of the proceedings and verdict

Name of person conducting autopsy: Title:

Address:

First Physician Attending Deceased After Injury

Name:

Address:

Previous Medical History

Was deceased treated for any medical conditions within five years prior to accident? ☐ Yes ☐ No

If yes, please list physician(s) in attendance below:

Name: Medical condition:

Dates of treatment:

Address:

Name: Medical condition:

Dates of treatment:

Address:

Name: Medical condition:

Dates of treatment:

Address:

By signing below I hereby certify that these statements and answers are true and correct to the best of my knowledge and belief.

Signature of beneficiary/claimant: Dated:

Address:

Authorization and Assignment of Benefits

I *authorize* any physician, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to _____ , deceased, to give us or our legal representative any and all such information for the purpose of evaluating a claim for benefits.

I *understand* the information obtained by use of this authorization will be used by ACE American Insurance Company or any of its affiliates to determine eligibility for benefits under the policy insuring said deceased. Any information obtained will not be released by us to any person or organization except to reinsuring companies, policyholders or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, permitted or as I may further authorize.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.

I *agree* this Authorization shall be valid for two years from the date shown below.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative, Beneficiary, or Next of Kin:

Dated:

Address:

Fraud Warning:
Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic Warning:
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Florida
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York
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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland/Oregon
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Virginia
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may have violated state law.

Chubb. Insured.℠