



Accidental Dismemberment 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 email your completed Claim Form along with the police/accident report, medical records, and witness statement to

Chubb USA
PO Box 816
Portland, ME 04104

800.336.0627 Inside USA
302.476.6194 Outside USA
ChubbAandHClaims@Chubb.com

Policyholder Name:

Policy Number(s):

Insured Statement

Full Name: _____ SSN: _____

Home Address: _____

Date of Birth: _____ Place of Birth: _____

Employed by: _____

Occupation: _____ Annual Salary: _____

Employer Address: _____

Describe Duties: _____

Accident Information

When did it happen? _____ Where did it happen? _____

How did it happen? _____

What were you doing at the time? _____

What injury did you receive? _____

When did you stop working? _____

Name and Addresses of All Physicians Consulted

Name: _____ Date of Treatment: _____

Address: _____

Name: _____ Date of Treatment: _____

Address: _____

Name: _____ Date of Treatment: _____

Address: _____

What operation was performed? _____

If in a hospital, which one? _____

Name and Addresses of Witnesses to Your Accident

Name: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

Employer's or Administrator's Statement

Group Policy No.: _____ Certificate No. (if applicable): _____

Policyholder Name: _____

Occupation: _____ Annual Salary: _____

Amount of Insurance: _____ Insurance Effective Date: _____

Length of Employment — From: _____ To: _____ Date Cancelled (if applicable): _____

Address: _____

Date of Accident: _____ Last Date at Work: _____

Signature of Official Representative: _____ Dated: _____

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:

Dated:

Address:

Attending Physician Statement

Patient's Name:

Date of Birth:

Patient's Address:

Diagnosis:

If loss is sight, is loss in both eyes? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, visual acuity at this time:

If loss is hearing, is loss in both ears? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, hearing at this time:

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No

If no, speech at this time:

If loss is extremity, where is severance?

In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

In your opinion, was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, list dates you provided treatment for this illness:

Please give an account of the accident as you understand it happened:

Dates of treatment for this accident:

To your knowledge, has the patient ever been treated for this same condition? ☐ Yes ☐ No

If yes, please explain:

Remarks:

Name (Attending Physician):

Phone No:

Address:

Signature of Insured or Authorized Rep:

Dated:

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 to 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 process of an 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.SM