Accidental Loss of Life

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____

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.** _________________________