



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: _____ Dates of partial disability: _____
 From: ____/____/____ through: ____/____/____ 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. _____