CHUBB

Chubb Travel Protection Claim Form

Accidental Death & Dismemberment / Flight Accident

Instructions

When reporting the claim please provide your name, Policy ID number, type of claim, and preferred contact information. Once you have completely filled out the appropriate sections of the claim form, submit it to *Administrative Concepts, Inc.* (contact information below). In addition to the claim form, you may be required to provide other specific information. In order to expedite your claim, please provide the applicable documentation based on the coverage(s) you are claiming. A claim form should be completed for each policy issued.

Quick Reference Guide

☐ **Accidental Death**

- Certified copy of the final death certificate
- Police report, any autopsy report, any medical records or reports, and any newspaper clippings
- Travel itinerary

☐ **Accidental Dismemberment**

- Policy report, all medical records, any eyewitness statements and complete accident details
- Travel itinerary

Please email your completed claim form with legible documentation to:

Administrative Concepts, Inc.
994 Old Eagle School Road Suite 1005 Wayne, PA 19087-1802
Email: chubbtravel@acitpa.com

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All Sections need to be completed for claims submissions.

I. General Information – *please complete or provide a copy of your policy confirmation statement*

Plan Purchased _____ Policy ID Number _____

Travel Company Name _____ Date of Booking _____

Trip Departure Date _____ Trip Return Date _____

Primary Insured Name _____ Primary Insured Date of Birth _____

Parent or Guardian Name if Primary Insured is under 18 _____

Home Phone # _____ Work Phone # _____

Please provide telephone numbers with country and city codes.

Mailing Address _____

Email Address _____

Preferred Contact Method_____

Reason for Claim:

_____

_____

_____

II. Coverage Information

Do you have any other insurance? ☐ Yes ☐ No

If yes, please provide source of insurance _____

Are claim expenses recoverable for another source? _____

If yes, please provide details and amounts:

_____

_____

_____

III. Payment Information *(funds will be issued in U.S. currency)*

Payment to Insured, Guardian or Beneficiary

☐ Mailing address listed on page 2

☐ Direct deposit to your checking account ☐ Direct deposit to your savings account

Name on Account _____

Bank Name _____ Bank Account Number _____

Bank Address _____ Bank Routing # or Swift Code _____

IBAN _____

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IV. Accidental Injury or Death Claim Information *(see list of required documents on page 1)*

Name: _____ Date and time of accident: _____

Give details of the accident:

_____

_____

_____

_____

Name and addresses of witnesses to accident:

_____

_____

_____

_____

Diagnosis:

_____

_____

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

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

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

If loss is extremity, where is severance? _____

Was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

Was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, list dates you received treatment for this illness: _____

Name and addresses of all physicians consulted

Primary Care Physician: _____

Primary Care Physician City, State: _____

Primary Care Physician Phone #: _____

Name: _____ Date of treatment: _____

Address: _____

Name: _____ Date of treatment: _____

Address: _____

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IV. Accidental Injury or Death Claim Information *(continued)*

What operation was performed? _____

If in a hospital, which one: _____

If in a hospital, dates hospitalized: From _____ To _____

If accident resulted in death, please fill out the below information:

Was there a judicial ruling made on the cause of death by a judge or jury? ☐ 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

Primary Care Physician: _____

Primary Care Physician City, State: _____

Primary Care Physician Phone #: _____

Was deceased treated for any medical conditions within 5 years prior to accident? ☐ Yes ☐ No

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

Name: _____

Address: _____

Medical condition: _____

Dates of treatment: _____

Name: _____

Address: _____

Medical condition: _____

Dates of treatment: _____

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: _____

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V. Declaration *(if signing electronically, do not lock document until 3rd signature is complete)*

I declare that the information given is to the best of my knowledge and belief, full, true, and correct:

Signed _____ **Date** _____

Authorization and Assignment of Benefits

I, the undersigned, authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information.

I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

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

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 _____

Relationship *(if other than Insured)*_____ **Date** _____

Mailing Address_____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Signature _____ **Date** _____

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Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud statement. 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 claim for the 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 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.

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