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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.
PO Box 4000; Collegeville, PA 19426
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 from another source? ☐ Yes ☐ No

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 NOTICES

For all states not specified below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

For residents of Arkansas: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

For residents of the District of Columbia: 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.

For residents of 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 IN THE THIRD DEGREE.

For residents of Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto, or conceals, for the purpose of misleading, information concerning any fact material thereto.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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For residents of 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 material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

For residents of Ohio: 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 is guilty of insurance fraud.

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

For residents of Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: 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 material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

For residents of Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

For residents of Virginia: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FLALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATE STATE LAW.

For residents of Washington: **It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**

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