LBT Accelerated Death Claim

CHUBB

HOW TO FILE AN ACCELERATED DEATH CLAIM—EMPLOYEE INSTRUCTIONS

☐ Complete Section A - Employee/Employer Information, Section B- Claimant's Statement, the Authorization To Obtain And Disclose Information and the Consent To Electronic Transactions and Payments forms. Sign and date the forms, then submit using one of the methods shown below.

☐ Provide your physician with Section C - Attending Physician's Statement. This will need to be completed by the physician that is currently treating the employee.

*If filing a dependent claim, it will need to be completed by the physician that is currently treating the dependent.

Please note by electing to receive these benefits, the life insurance will be reduced by the amount received. The Accelerated Benefit is available on a voluntary basis. Premium payments must continue to be paid on the full amount of the life insurance. Receipt of Accelerated Benefits may be taxable. Assistance should be sought from a personal tax advisor. The receipt of these Accelerated Benefits may affect eligibility for public assistance.

- **E-mail:** cwbclaimsteam@chubb.com
- **Fax**: 312-351-7120
- **Mail:** Chubb Workplace Benefits
  Claim Department
  PO Box 6700
  Scranton, PA 18505-0700

If you have any questions about the claim process or how to complete this form, please call 833-542-2013.

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A business unit of Combined Insurance Company of America, a Chubb Company
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FRAUD NOTIFICATIONS

If you are a resident of or if the policy was issued in one of the following states, we are required to provide you with the following Fraud Warning Notification:

ARKANSAS, LOUISIANA, 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.

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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 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. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or member for the purpose of defrauding or attempting to defraud the policyholder or member with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with the intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: 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.

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 a denial of insurance benefits.

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.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

FRAUD NOTIFICATIONS CONTINUED

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.

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.

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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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 and denial of insurance benefits.

TEXAS: Any person who knowingly presents a 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.

VIRGINIA: 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.

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.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and/or civil penalties.

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SECTION A PLEASE PRINT	EMPLOYEE/EMPLOYER INFORMATION		
NAME OF EMPLOYEE/INSURED PERSON	SOCIAL SECURITY NO. (LAST 4 DIGITS)	DATE OF BIRTH (MM/DD/YYYY)	
PHONE NO.	GROUP NO.		
EMPLOYEE'S/INSURED PERSON'S STREET ADDRESS	CITY	STATE	ZIP
EMPLOYER/BUSINESS ENTITY	EMPLOYER/BUSINESS ENTITY PHONE NO.		
EMPLOYER'S/BUSINESS ENTITY'S STREET ADDRESS	CITY	STATE	ZIP

SECTION B	CLAIMANT'S STATEMENT		
NAME	RELATIONSHIP TO EMPLOYEE	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP
DESCRIBE CONDITION FOR WHICH CLAIM IS BEING MADE:			
NAME OF ATTENDING PHYSICIAN	PHONE NO.		
STREET ADDRESS	CITY	STATE	ZIP
NAME OF HOSPITAL	DATE ADMITTED	DATE DISCHARGED	
STREET ADDRESS	CITY	STATE	ZIP

NAME, ADDRESS, AND TELEPHONE NUMBER OF PERSON ASSISTING WITH CLAIM (IF ANY)			
NAME	RELATIONSHIP	PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP
ATTACH A COPY OF LEGAL INSTRUMENT. CHECK ONE: ☐ POWER OF ATTORNEY ☐ GUARDIANSHIP			

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

REQUIRED SIGNATURE OF CLAIMANT

By making claim to these proceeds, I declare that all the answers recorded on this statement are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

X_____ _____ _____
CLAIMANT'S SIGNATURE | DATE | PLEASE PRINT NAME

I signed on behalf of the member, as _____ (relationship). If you are the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

If your policy/certificate is paid with pre-tax dollars, benefits paid may be reported to the IRS. Contact your Employer regarding reporting requirements.

You must sign and date this claim form on the signature line provided on this page. If you do not sign this claim form, we cannot accept your claim submission.

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SECTION C — ATTENDING PHYSICIAN'S STATEMENT

PATIENT NAME	DATE OF BIRTH	CLAIM NUMBER (IF AVAILABLE)	POLICY NUMBER (IF AVAILABLE)

DIAGNOSIS	DATE DIAGNOSED (MM/DD/YYYY)

HAVE YOU DIAGNOSED THIS PATIENT AS TERMINALLY ILL? ☐ YES ☐ NO	IF YES, DATE THE CONDITION BECAME TERMINAL (MM/DD/YYYY)

WHAT IS THE PATIENT'S LIFE EXPECTANCY? (MUST CHECK ONE) ☐ LESS THAN 6 MONTHS ☐ 6-12 MONTHS ☐ 12-24 MONTHS ☐ GREATER THAN 24 MONTHS
IF UNABLE TO DETERMINE LIFE EXPECTANCY, PLEASE INCLUDE THE LAST THREE MONTHS OF MEDICAL RECORDS.

DURING THE LAST SIX MONTHS, HAS THE PATIENT: ☐ RECOVERED ☐ IMPROVED ☐ RETROGRESSED ☐ UNCHANGED

THE PATIENT CURRENTLY IS: ☐ AMBULATORY ☐ BED CONFINED ☐ HOUSE CONFINED ☐ HOSPITAL CONFINED ☐ HOSPICE CONFINED	AS OF (MM/DD/YYYY)

OTHER PROVIDERS: ARE YOU AWARE OF OR HAVE YOU REFERRED YOUR PATIENT TO OTHER TREATING PROVIDERS? IF YES, PLEASE PROVIDE COMPLETE NAME, CONTACT INFORMATION, AND SPECIALTY OF ANY OTHER TREATING PHYSICIANS OR HOSPITALS.

NAME	SPECIALTY	ADDRESS	TELEPHONE

INFORMATION ABOUT CANCER - PLEASE COMPLETE THIS SECTION IF THE PATIENT HAS BEEN DIAGNOSED WITH CANCER.

PLEASE CHECK THE CURRENT STAGE: ☐ I ☐ II ☐ III ☐ IV

DATE OF DISTANT METASTASIS (ES):	LOCATION OF METASTASIS (ES):

INFORMATION ABOUT HEART DISEASE - PLEASE COMPLETE THIS SECTION IF THE PATIENT HAS BEEN DIAGNOSED WITH HEART DISEASE.

FUNCTIONAL CAPACITY (AMERICAN HEART ASSOCIATION)
☐ CLASS 1 (NO LIMITATION) ☐ CLASS 3 (MARKED LIMITATION)
☐ CLASS 2 (SLIGHT LIMITATION) ☐ CLASS 3 (COMPLETE LIMITATION)

THERAPEUTIC CLASS (ACTIVITY)
☐ A. NO RESTRICTIONS ☐ D. MARKED RESTRICTIONS
☐ B. SLIGHT RESTRICTIONS ☐ E. COMPLETE RESTRICTIONS
☐ C. MODERATE RESTRICTIONS

ATTENDING PHYSICIAN VERIFICATION

I AM AWARE THAT IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE RELEVANT AND IMPORTANT. I CERTIFY THAT THE ANSWERS GIVEN ON THIS FORM ARE TRUE, COMPLETE, AND CORRECTLY RECORDED.

PHYSICIAN NAME (PLEASE PRINT)	MEDICAL SPECIALTY

ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER	FAX NUMBER

X _____ _____

SIGNATURE OF PHYSICIAN DATE

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CONSENT TO ELECTRONIC TRANSACTIONS AND PAYMENTS

1. Consent to Electronic Transactions

By signing and dating this form, you acknowledge, agree and consent to the use by Combined Insurance Company of America, Combined Life Insurance Company of New York, and/or ACE Property & Casualty Insurance Company, each a Chubb Group Company ("Chubb"), of electronic transactions, electronic signatures, and to the receipt of the electronic version of certain documents and records, including but not limited to policy delivery, acknowledgements, notices (including, without limitation, privacy notices), forms, invoices, explanation of benefits, proof of loss, claims documentation, releases, authorizations to obtain medical records, affidavits, and disclosures, to the extent permitted by law. Electronic documents will be sent to the email address on file. This consent unless withdrawn applies to all transactions between you and Chubb.

You specifically acknowledge as part of your consent that certain documents delivered electronically will contain confidential information and information regarding your personal financial matters ("Personal Financial Information") and other personally identifiable information; and consent to the delivery of such confidential information, Personal Financial Information and personally identifiable information by electronic means. The consent that you grant shall remain in effect until withdrawn by you.

You specifically acknowledge as part of your consent that we will replace paper delivery of any particular document with electronic delivery at our sole discretion as electronic delivery of particular documents becomes available and are consenting to delivery of documents to you in the following manner: We may send you email transmitting such documents, whether as text in, attachments to, and/or hyperlinks from such emails. Such emails will be sent to the current email address we have on file for you. You are responsible for providing us with a valid email address to which you have regular access and you are responsible for immediately notifying us of any change of email address. Any change to your email address can be completed by calling Chubb Workplace Benefits at 833-542-2013 Monday through Friday between the hours of 7:00am to 6:00pm Central Time.

You have the right to receive communications from Chubb in paper form. You may withdraw this consent at any time. To withdraw your consent, you may call our Customer Service Department at 1-833-542-2013, Monday through Friday between 7:30 am and 6:00 pm CST. Your withdrawal will not affect or change in any way the legal effectiveness, validity or enforceability of any documents that were delivered to you electronically before your withdrawal became effective.

To request a paper copy of any document that was originally provided to you electronically, at no charge, please call our Customer Service Department.

2. Consent to Electronic Payment

If you submit a payable claim, Chubb may offer you the option to receive your benefit payment electronically via bank transfer into a checking account, transfer into a PayPal account, or transfer to a debit card (as available). Chubb will not impose any fees on you for choosing to accept your payment electronically, but your financial institution may impose a fee or charge. By signing and dating this form, you are accepting this offer and consenting to accept benefit payments electronically. Consenting to accept payment electronically is voluntary. Your payments received through electronic transfer may be subject to attachment or garnishment if your account is subject to the same.

If any portion of your claim is payable, you will receive an email with a link to setup an account and provide the routing and account number for the bank or other account where you wish the funds be deposited. If you do not set up an account and provide the account information within three (3) calendar days, we will automatically issue the payment via a check mailed to the address on file.

Unclaimed funds are subject to the applicable laws concerning unclaimed property.

By signing and dating this form, you attest that you are the Principal Insured under the coverage for which your claim was submitted.

3. Consent to Electronic Signature

You also agree that your electronic signature is the legal equivalent of your manual signature on the above listed documents. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise agree, acknowledge, consent, opt-in, or certify to any of the above documents constitutes your signature, acceptance and agreement as if manually signed by you in writing. You agree that no certification authority or other third-party verification is necessary to validate such signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of such signature or any such document. You represent that you will be bound by the terms of this consent. This consent for electronic delivery and signature is effective until withdrawn by you. Doing business electronically will not affect the validity, legal effect or enforceability of any of your transactions with Chubb.

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CONSENT TO ELECTRONIC TRANSACTIONS AND PAYMENTS - Continued

You are responsible for ensuring that neither your software nor your Internet service provider inhibits or interferes with the notices and communications described herein. To ensure delivery of your policy, claim, and/or other documents, the following minimum hardware and system requirements are necessary to sign, print, retain and receive such documents.

Operating Systems	Windows® 7 or 8.1 or MAC
Browsers	Final release versions of Internet Explorer® 9.0 or above (Windows only); Firefox 34 or above (Windows and Mac); Safari™ 5.0 or above (Mac only); Google Chrome 39 or above; Apple iOS 7 or above; Android 4.4 and above
PDF Reader	Acrobat Reader® or similar software may be required to view and print PDF files
Screen Resolution	800 x 600 minimum
Enabled Security Settings	Allow per session cookies

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements necessary to print, store and receive claims documents electronically and that you may be able to access such documents for future reference.

Print Name _____

Signature_____

E-mail Address _____

Date_____

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Claim or Policy Number:_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ /_____ /_____

This will authorize CHUBB to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, Union, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated. I further authorize CHUBB to rely on this authorization for two years, or as otherwise permitted by law, to disclose information about me for purposes of processing my insurance claims, including assistance with return to work.

The information to be disclosed may include but is not limited to:

History of Present Illness	Consultant's Report	Discharge Summary
Operative Reports	Pathology Reports	Laboratory Results
Daily Doctor's Notes	Past Medical History	Previous Admissions
X-Ray Reports	Blood/Toxicology	

The information is needed for the following purpose(s): Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will expire (24) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to CHUBB. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy/certificate or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

X _____ Date: _____
(Signature of Claimant) (Must be filled in)

X _____ _____
(Signature of Parent or Guardian) (Relationship to Patient if Signed by Guardian)

A photocopy of this authorization may be treated in the same manner as an original.