CHUBB

Accident Claim Form

Chubb Workplace Benefits • Claim Department • P.O. Box 6803 • Scranton, PA 18505-6803
Telephone 1-833-542-2013 • Fax 312-351-7120 • www.chubb.com/WorkplaceBenefitsClaims

Ways to submit your claim:

1. **Self Service Online Submission*:** www.chubb.com/WorkplaceBenefitsClaims
2. **Mail this Completed Form:** Chubb Workplace Benefits, Claim Department, P.O. Box 6803, Scranton, PA 18505-6803
3. **Fax this Completed Form:** (312) 351-7120

*Your claim may be processed faster when you submit a claim online.

Accident Claim Checklist

- ☐ Section(s) 1, 2 to be completed by Policy / Certificate Holder and Claimant.
  - Attach proof of injury, such as emergency records, itemized bills, a copy of the hospital itemized bill (Hospital form UB04) that details the number of days hospitalized and type of inpatient care (General Inpatient, ICU, Rehab, etc.), medical records, CT/MRI reports, Physical Therapy reports, death certificate and autopsy report (if filing for accidental death benefits), copy of police report.
- ☐ Section 3 Attending Physician Statement – To be completed by licensed physician.
- ☐ Section 4 Authorization to Obtain and Disclose Information - to be completed, signed, and dated by Claimant.
- ☐ Section 5 Consent to Electronic Transactions, Payments and Signature - to be completed, signed, and dated by Policy / Certificate Holder.
- ☐ Section(s) 6, 7 Fraud Warnings to be completed by the Claimant.
- ☐ Submit the completed form using one of the methods shown above.

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

If you have any questions about the claim process, how to complete this form, or require assistance to log onto the self-service portal, please call 1-833-542-2013.

You MUST sign and date this claim form in all the applicable signature boxes provided. If you do not sign all the applicable signature boxes provided, we cannot accept your claim submission.

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Section 1 – Policy/Certificate Holder Information

First Name | Middle Initial | Last Name | Policy/Certificate Numbers

Date of Birth MM/DD/YYYY (/ /) | Age | Gender ☐ Male ☐ Female | Social Security No. (last 4 digits) ( )

Address

City | State | Zip

Email | Phone

Is this claim for someone other than the policy holder? ☐ Yes ☐ No

If yes, what is their relationship to the employee/member: ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child/Stepchild

Dependent First Name | Middle Initial | Last Name | Date of Birth (/ /) MM/DD/YYYY

List Other Names You May Use Such as Maiden Name, Nickname, etc.

Social Security No. (last 4 digits) ( ) | Gender ☐ Male ☐ Female

Address

City | State | Zip

Email | Primary Phone | Secondary Phone

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Section 2 – Accident Information

First Name | Middle Initial | Last Name | Date of Birth (MM/DD/YYYY) | Policy/Certificate Numbers

Date of Accident (MM/DD/YYYY) | Date of Initial Exam by Medical Provider (MM/DD/YYYY) | Medical Provider Name

Have you ever had the same kind of injury before? ☐ Yes ☐ No

Medical Provider Address

City | Province/State | Zip

Did this accident/injury happen at work? ☐ Yes ☐ No

Is this accident/injury covered by Worker' Compensation? ☐ Yes ☐ No

Is this a sport related injury? ☐ Yes ☐ No

If yes, provide the name of the sport organization

Were you hospitalized? ☐ Yes ☐ No

If yes, provide the hospital name

Hospital admission date (MM/DD/YYYY) Hospital discharge date (MM/DD/YYYY)

Were you in the ICU? ☐ Yes ☐ No

If yes, provide the hospital name

ICU admission date (MM/DD/YYYY) ICU discharge date (MM/DD/YYYY)

Were you admitted to a Rehabilitation Hospital? ☐ Yes ☐ No

If yes, provide the rehabilitation hospital name

Rehab admission date (MM/DD/YYYY) Rehab discharge date (MM/DD/YYYY)

Were you transported by ambulance (ground or air)? Ground ☐ Yes ☐ No Air ☐ Yes ☐ No

If yes, provide the name of the transport provider

Please provide a brief description of the accident and injury sustained (describe how accident occurred and the nature of the injury):

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Section 3 – Attending Physician Statement

Claimant Name | Date of Birth (MM/DD/YYYY) | Claim Number (if available) | Policy Number (if available)

Describe the Condition

ICD 9/10 Code | Primary Diagnosis

Other Condition(s)

Nature and origin of condition: ☐ Sickness ☐ Injury

When did the symptoms first appear? / / (MM/DD/YYYY) If applicable, what was the accident date? / / (MM/DD/YYYY)

When did the claimant first consult with you for this condition? / / (MM/DD/YYYY)

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when?

Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Pregnancy or Complication of Pregnancy:

Due Date / / (MM/DD/YYYY) Delivery Date / / (MM/DD/YYYY) ☐ Normal Delivery ☐ C-Section ☐ Complications of Pregnancy

Was baby admitted to NICU? ☐ Yes ☐ No If yes, provide dates

Treatment Required

First Consultation / / (MM/DD/YYYY) | Most Recent Consultation / / (MM/DD/YYYY) | Next Consultation / / (MM/DD/YYYY) | Released / / (MM/DD/YYYY)

If sickness, when was the condition first diagnosed? / / (MM/DD/YYYY)

Is/was diagnostic testing performed? ☐ Yes ☐ No

Test(s) Dates

Result: Please include supporting documentation

Is/was a surgical or medical procedure required? ☐ Yes ☐ No Date / / (MM/DD/YYYY) Procedure Code

Procedure

Is/was hospitalization required? ☐ Yes ☐ No Admission Date / / (MM/DD/YYYY) Discharge Date / / (MM/DD/YYYY)

Hospital | City | State

What is the current treatment plan?

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Section 3 – Attending Physician Statement Continued

Treatment Required Continued

Is/was Office/Urgent Care required? ☐ Yes ☐ No Date / / MM/DD/YYYY Name of Facility

Nature of Treatment

Is/was Emergency Room required? ☐ Yes ☐ No Date / / MM/DD/YYYY Name of Facility

Nature of Treatment

The patient is unable to perform their job duties ☐ Yes ☐ No

If yes, please provide the total disability dates from / / MM/DD/YYYY through / / MM/DD/YYYY

When is the patient expected to resume part time/partial duties? / / MM/DD/YYYY Full Time/Full Duties / / MM/DD/YYYY

The restrictions and limitations are ☐ Temporary. If so, how long? ☐ Permanent

What are the current restrictions and limitations?

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 Signature | Date / / MM/DD/YYYY | Print Name

Specialty | Phone Number

Address | City | State | Zip Code

Fax Number | Email | License Number

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Section 4 – Authorization to Obtain and Disclose Information

Claim or Policy Number (if known)

First Name | Last Name | Date of Birth (MM/DD/YYYY)

Address

City | State | Zip

This will authorize CHUBB WORKPLACE BENEFITS and its affiliated companies, Combined Insurance Company of America and ACE Property & Casualty Insurance Company ("Chubb"), PO BOX 6803, Scranton, PA. 18505-6803 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, employer, 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 Combined 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 Reports	Discharge Summary
Objective 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 WORKPLACE BENEFITS and its affiliated companies, Combined Insurance Company of America and ACE Property & Casualty Insurance Company ("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.

Signature of Claimant | Date (MM/DD/YYYY)

Signature of Parent of Guardian | Relationship to Patient is Signed by Guardian

If signature is provided by Legal Representative, please attach documentation of legal status.

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Section 5 – Consent To Electronic Transactions, Payments And Signature

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 and its affiliated company ACE Property & Casualty Insurance Company ("Combined" or "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, acknowledgments, 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 delivered online to your Chubb Workplace Benefits Self-Service Account. You will be notified via email when delivered. 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 through our Self-Service portal at chubb.com/workplacebenefitsclaims or by calling the Customer Service Department.

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 or go to chubb.com/workplacebenefitsclaims to fill out and submit a General Inquiries form. 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.

Confirmation of Computer or Electronic Device System Requirements

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

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Section 5 – Consent To Electronic Transactions, Payments And Signature Continued

2. 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.

3. 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.

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.

By signing and dating this form, you are confirming that your computer or electronic device meets the system requirements, consenting to do business electronically and consenting to receive claim payments electronically.

PLEASE NOTE: If you wish to receive your claim payment(s) electronically, please return both pages of Section 5.

If you wish to receive a paper check in the mail, DO NOT include Section 5 with your claim submission.

Print Name

Date
/ /
MM/DD/YYYY

Signature

Email Address

Phone Number

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Section 6 – Fraud Warnings

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.

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 FORM PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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.

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Section 6 – Fraud Warnings Continued

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.

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.

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Section 6 – Fraud Warnings Continued

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.

Section 7 – Required Signature of Claimant

NEW YORK FRAUD NOTIFICATION: 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.

Signature of Claimant

Date

/ /

MM/DD/YYYY

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.**