

Claims Made Easy

CHUBB®



HOW TO FILE YOUR CLAIM Please Follow the Simple Steps Below

1. Download the claim form available online at www.chubb.com/WorkplaceBenefitsClaims. Complete sections based on the claim type.

For Accident Claims

1. Complete Sections A, A-1 and A-3.
2. Have your physician complete Section C.

For Critical Illness and Cancer Advocate Plus Claims

1. Complete Sections A, A-2 and A-3.
2. Have your physician complete Section C.

For Disability Claims

1. Complete Sections A and A-4.
2. Have your employer complete Section B.
3. Have your physician complete Section C.

For Hospital Indemnity Claims

1. For hospitalization due to an accident, complete Sections A and A-5.
2. For hospitalization due to a sickness, complete Sections A and A-5.

2. Review, sign and date the claim form and Fraud Notification on the signature line provided on page 7 at the end of the Fraud Notification. If you do not sign the fraud statement we cannot accept your claim submission.
3. You may elect to receive documents and payments electronically. To do so, please complete and sign the Consent to Electronic Transactions, Payments and Signature document.
4. Sign and date the Authorization to Obtain and Disclose Health Information.
5. Send your signed, completed claim form with the Attending Physician's Statement, Employer Statement, if applicable, and any medical bills or documentation that you may have related to your accident or illness to:

Chubb Workplace Benefits

Claim Department
PO Box 6803
Scranton, PA 18505-6803



Claims Made Easy - Helpful Tips

First page (Insured completes)

Please include your complete name and current mailing address on the claim form as any payment and/or correspondence will be sent to the address indicated on the claim form. Indicate your policy numbers/certificate numbers on the claim form; this will help us respond quicker.



Accident: For loss due to an accidental bodily injury, please complete the Accident section of the form including a detailed description of how the accident occurred.



Critical Illness or Cancer Advocate Plus: If filing a critical illness or cancer claim, please fill in the date of diagnosis and provide a copy of the pathology report or test results confirming the diagnosis.



Disability: If you were disabled and have disability coverage, give the exact dates of the total and/or partial disability. If you are still disabled at the time you submit your claim form, another claim form will be sent to you for continuing disability.



Hospital Indemnity: If filing a hospital indemnity claim, please complete the Hospital Indemnity section of the form and provide an itemized hospital bill.



Wellness: If filing for wellness/preventative/health screening benefits, please review your policy carefully to ensure the test or procedure is covered under your policy. **Do not use the attached claim form if filing for wellness or health screening benefits.** Rather use the Health and Wellness claim form which can be found at www.chubb.com/WorkplaceBenefitsClaims.

Additional: Please be sure to sign and date the Authorization to Release Information. This will prevent unnecessary delays in the event additional information is needed.

Fourth page (Employer completes)

If you are employed, your employer must verify your disability by completing Section B - Employer's Statement.

Fifth page (Doctor completes)

Your primary physician must complete Section C - Attending Physician's Statement in its entirety. Please make sure your physician fills in all necessary information to avoid delays in processing your claim.

For your records, we suggest that you keep a copy of the completed claim form and any bills you submit. Note the date mailed. Mail all pages of the completed form and any enclosures to:

Chubb Workplace Benefits

Claim Department
PO Box 6803
Scranton, PA 18505-6803

Ninth page (Insured completes)

If your claim is Approved and you would like to receive electronic payments, you must submit the Consent form along with your claim form.

IMPORTANT INSTRUCTIONS FOR FILING A CLAIM

1. USE THIS CLAIM FORM FOR ACCIDENT, CANCER ADVOCATE PLUS, CRITICAL ILLNESS, DISABILITY and HOSPITAL INDEMNITY.
2. IF DISABILITY IS CLAIMED, PLEASE HAVE YOUR EMPLOYER COMPLETE SECTION B, THE EMPLOYER'S STATEMENT.
3. IF MEDICAL OR HOSPITAL BENEFITS ARE CLAIMED, ITEMIZED BILLS MUST BE ATTACHED.

SECTION A				CLAIMANT STATEMENT (ALL CLAIMS)			
PLEASE PRINT							
FIRST NAME				LAST NAME			M.I.
E-MAIL ADDRESS (Your e-mail address will be updated with this information if different from the e-mail on file.)							
PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC.				PRIMARY PHONE		SECONDARY PHONE	
MAILING ADDRESS							
CITY						STATE	ZIP
SOCIAL SECURITY # (LAST 4 DIGITS)		BIRTH DATE (MM/DD/YYYY)		HEIGHT (FT/IN)	WEIGHT (LBS)	MALE	FEMALE
POLICY/CERTIFICATE NUMBER(S)							
EMPLOYER'S NAME							
EMPLOYER'S ADDRESS							
CITY						STATE	ZIP

SECTION A-1		CLAIMANT STATEMENT (ACCIDENT CLAIM)	
PLEASE COMPLETE ALL APPLICABLE SECTIONS BELOW AND SUBMIT DOCUMENTATION TO SUBSTANTIATE COVERED SERVICES CLAIMED UNDER YOUR POLICY.			
COMPLETE FOR AN ACCIDENT CLAIM, THEN COMPLETE SECTION A-3.			
DATE OF ACCIDENT (MM/DD/YYYY)		INJURIES SUSTAINED	
PLEASE PROVIDE AN EXACT DESCRIPTION OF WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF WHAT HAPPENED TO YOU.			

SECTION A-2		CLAIMANT STATEMENT (CRITICAL ILLNESS OR CANCER ADVOCATE PLUS CLAIM)	
COMPLETE FOR A CRITICAL ILLNESS or CANCER ADVOCATE PLUS CLAIM, THEN COMPLETE SECTION A-3.			
DATE OF CRITICAL ILLNESS or CANCER DIAGNOSIS (MM/DD/YYYY)		CRITICAL ILLNESS OR CANCER DIAGNOSIS IF KNOWN	
PLEASE PROVIDE A COPY OF THE PATHOLOGY REPORT OR TEST(S) THAT CONFIRM THE DIAGNOSIS AND ANY ADDITIONAL DETAILS, INCLUDING SYMPTOMS.			

Statements made by you on this claim form must be true and complete. Please review the Fraud Warning for your state on the attached Fraud Notification pages. You must sign and date this claim form on the signature line provided on the Fraud Notifications page. *If you do not sign this Fraud Notifications page, we cannot accept your claim submission.*

SECTION A-3

CLAIMANT STATEMENT

COMPLETE FOR EITHER: **ACCIDENT, CANCER ADVOCATE PLUS, CRITICAL ILLNESS, OR DISABILITY.** (HOSPITAL INDEMNITY USE A-5)

PRIMARY ATTENDING PHYSICIAN'S NAME			
ADDRESS			
CITY		STATE	ZIP
PHONE NUMBER	FAX NUMBER	INITIAL DATE OF TREATMENT (MM/DD/YYYY)	LAST DATE OF TREATMENT (MM/DD/YYYY)
OTHER ATTENDING PHYSICIAN'S OR SPECIALIST'S NAME			
ADDRESS			
CITY		STATE	ZIP
PHONE NUMBER	FAX NUMBER	INITIAL DATE OF TREATMENT (MM/DD/YYYY)	LAST DATE OF TREATMENT (MM/DD/YYYY)
HOSPITAL NAME			
HOSPITAL ADDRESS			
CITY		STATE	ZIP
PHONE NUMBER	FAX NUMBER	ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)

SECTION A-4

CLAIMANT STATEMENT (DISABILITY CLAIM)

COMPLETE FOR A **DISABILITY** CLAIM ONLY

EMPLOYER'S CONTACT NAME		EMPLOYER'S CONTACT PHONE NUMBER	EMPLOYER'S CONTACT FAX NUMBER
YOUR OCCUPATION			MONTHLY EARNINGS \$,
BRIEFLY DESCRIBE YOUR OCCUPATIONAL DUTIES			
HAVE YOU, OR DO YOU INTEND TO, FILE A CLAIM UNDER THE FOLLOWING: WORKERS' COMPENSATION ACT? YES <input type="checkbox"/> NO <input type="checkbox"/> SOCIAL SECURITY ACT? YES <input type="checkbox"/> NO <input type="checkbox"/> STATE DISABILITY BENEFITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			IF YES TO ANY OF THE PRECEDING, PLEASE SUBMIT A COPY OF THE AWARD OR DENIAL LETTER IF RECEIVED.
IF YOU HAVE OTHER ACCIDENT-SICKNESS DISABILITY INSURANCE, GIVE COMPANY NAME, ADDRESS, AND BENEFIT AMOUNT. (IF NONE, STATE "NONE")			
INSURANCE COMPANY NAME			
ADDRESS			
CITY		STATE	ZIP
BENEFIT AMOUNT		BENEFIT AMOUNT	
WEEKLY \$,	BI-WEEKLY \$,	MONTHLY \$,	
TOTAL DISABILITY: BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES? FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)		PARTIAL DISABILITY: BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES? FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)	
DATE LAST WORKED (MM/DD/YYYY)		DATE RETURNED TO WORK (MM/DD/YYYY)	

PLEASE HAVE YOUR EMPLOYER COMPLETE AND SIGN SECTION B — EMPLOYER'S STATEMENT FOUND ON PAGE 4.

COMPLETE FOR HOSPITAL INDEMNITY CLAIM

Please note that your coverage may not contain all benefits listed below. Refer to your policy/certificate for a complete description of available benefits. Supporting documents for your hospitalization reported in this claim form should include:

- a. the diagnosis
- b. the admission and discharge dates
- c. hospital admission and discharge summaries
- d. an itemized bill

The term Intensive Care Unit (ICU) includes Hospital units with the following names: Intensive Care Unit; Coronary Care Unit; Neonatal Intensive Care Unit; Burn Unit; or Transplant Unit.

WHAT WAS THE REASON FOR YOUR HOSPITALIZATION?

ARE YOU CLAIMING HOTEL LODGING BENEFITS FOR THIS HOSPITALIZATION?

YES NO IF YES, PLEASE SUBMIT THE HOTEL RECEIPT(S).

IS THIS HOSPITALIZATION DUE TO COMPLICATIONS OF PREGNANCY?

YES NO

ARE YOU CLAIMING AN AMBULANCE BENEFIT?

YES NO IF YES, PLEASE SUBMIT THE AMBULANCE RECEIPT(S).

ICU?

YES NO IF YOU ARE CLAIMING ICU HOSPITALIZATION BENEFITS, COMPLETE SECTION II.
 IF YOU ARE CLAIMING NON-ICU HOSPITALIZATION BENEFITS, COMPLETE SECTION I.
 IF YOU ARE CLAIMING EMERGENCY/URGENT CARE BENEFITS, COMPLETE SECTION III.
 IF YOU ARE CLAIMING REHABILITATION UNIT BENEFITS, COMPLETE SECTION IV.
 IF YOU ARE CLAIMING ANY OTHER BENEFITS, COMPLETE SECTION V

SECTION I NON-ICU HOSPITAL BENEFITS

DATE OF ADMISSION TO A NON-ICU UNIT OF THE HOSPITAL

DATE OF DISCHARGE TO A NON-ICU UNIT OF THE HOSPITAL

NAME OF FACILITY

ADMISSION DATE (MM/DD/YYYY)

DISCHARGE DATE (MM/DD/YYYY)

CITY

STATE

ZIP

SECTION II ICU HOSPITAL BENEFITS

DATE OF ADMISSION TO AN ICU UNIT OF THE HOSPITAL

DATE OF DISCHARGE TO AN ICU UNIT OF THE HOSPITAL

NAME OF FACILITY

ADMISSION DATE (MM/DD/YYYY)

DISCHARGE DATE (MM/DD/YYYY)

CITY

STATE

ZIP

SECTION III EMERGENCY/URGENT CARE BENEFITS

EMERGENCY ROOM (ER)

DATE (MM/DD/YYYY)

NATURE OF TREATMENT

NAME OF FACILITY

CITY

STATE

ZIP

URGENT CARE FACILITY

DATE (MM/DD/YYYY)

NATURE OF TREATMENT

NAME OF FACILITY

CITY

STATE

ZIP

SECTION IV REHABILITATION UNIT BENEFITS

DATE OF ADMISSION TO THE REHABILITATION

DATE OF DISCHARGE FROM THE REHABILITATION

NAME OF FACILITY

ADMISSION DATE (MM/DD/YYYY)

DISCHARGE DATE (MM/DD/YYYY)

CITY

STATE

ZIP

SECTION V ALL OTHER BENEFITS

PROVIDE DETAILED DESCRIPTION OF OTHER TREATMENT OR BENEFITS YOU ARE CLAIMING FOR.

ADMISSION DATE (MM/DD/YYYY)

DISCHARGE DATE (MM/DD/YYYY)

NAME OF FACILITY

CITY

STATE

ZIP

SECTION B

EMPLOYER'S STATEMENT

IF YOU ARE EMPLOYED, YOUR EMPLOYER MUST VERIFY YOUR DISABILITY BY COMPLETING SECTION B – EMPLOYER'S STATEMENT.

EMPLOYEE'S FIRST NAME	LAST NAME	M.I.
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CITY	STATE	ZIP
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PHONE NUMBER	BIRTH DATE (MM/DD/YYYY) / /	CLAIM NUMBER (IF AVAILABLE)
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DATE LAST WORKED (MM/DD/YYYY) / /	DATE RETURNED TO WORK (MM/DD/YYYY) / /	FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/>	MONTHLY EARNINGS \$,
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POLICY NUMBER(S)

EMPLOYEE'S OCCUPATION	DESCRIPTION OF PRIMARY OCCUPATIONAL DUTIES
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WAS EMPLOYEE INJURED ON THE JOB? YES <input type="checkbox"/> NO <input type="checkbox"/>	HAS (OR WILL) A WORKERS' COMPENSATION CLAIM BEEN FILED FOR THIS DISABILITY? YES <input type="checkbox"/> NO <input type="checkbox"/> PAID? YES <input type="checkbox"/> NO <input type="checkbox"/>
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IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION CARRIER. ALSO, SEND REPORT OF INITIAL INJURY.

NAME

ADDRESS

CITY	STATE	ZIP
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PHONE NUMBER

PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)

SITTING ^{H H M M} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PER DAY	WALKING ^{H H M M} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PER DAY	CLIMBING STAIRS/LADDERS ^{H H M M} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PER DAY	DRIVING ^{H H M M} <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PER DAY
LIFTING: <input type="checkbox"/> LESS THAN 10 LBS <input type="checkbox"/> 10 TO 20 LBS <input type="checkbox"/> MORE THAN 20 LBS		STOOPING/BENDING: <input type="checkbox"/> NONE <input type="checkbox"/> SELDOM <input type="checkbox"/> FREQUENT	

TOTAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES? FROM (MM/DD/YYYY) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> THROUGH (MM/DD/YYYY) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>	PARTIAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES? FROM (MM/DD/YYYY) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> THROUGH (MM/DD/YYYY) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/>
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DURING PARTIAL DISABILITY, WHAT PERCENTAGE OF PRE-DISABILITY INCOME DID/WILL THE EMPLOYEE RECEIVE? _____ %

DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)
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EMPLOYER CONTACT NAME	CONTACT'S POSITION	DATE (MM/DD/YYYY) / /
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SIGNATURE	PHONE NUMBER	FAX NUMBER
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SECTION C

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME	LAST NAME	M.I.	AGE
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ADDRESS

CITY STATE ZIP

NATURE AND ORIGIN OF: SICKNESS INJURY

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? (MM/DD/YYYY) WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MM/DD/YYYY) IF SICKNESS, WHEN WAS CONDITION FIRST DIAGNOSED? (MM/DD/YYYY)

INDICATE THE DATE AND TYPE OF DIAGNOSTIC TEST USED TO DIAGNOSE CURRENT CONDITION. IF MORE TESTS WERE PERFORMED, PLEASE INCLUDE SUPPORTING DOCUMENTATION. (MM/DD/YYYY)

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES NO (IF "YES", STATE WHEN AND DESCRIBE.) (MM/DD/YYYY)

DESCRIBE ANY OTHER MEDICAL CONDITION IMPACTING THE PATIENT.

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)

DATE (MM/DD/YYYY) PROCEDURE NAME OF FACILITY

OPEN OR CLOSED REDUCTION
OPEN CLOSED

GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.

OFFICE DATE (MM/DD/YYYY) NATURE OF TREATMENT(S) NAME OF FACILITY

EMERGENCY ROOM (ER) DATE (MM/DD/YYYY) NATURE OF TREATMENT NAME OF FACILITY

URGENT CARE FACILITY DATE (MM/DD/YYYY) NATURE OF TREATMENT NAME OF FACILITY

PLEASE STATE RESTRICTIONS PLACED ON PATIENT FOR ANY DISABILITY THAT HAS BEEN INDICATED.

IS THE PATIENT STILL UNDER YOUR CARE? YES NO

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)? FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)? FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)

IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE? YES NO (IF "YES", INDICATE THE RETURN TO WORK DATE.) → RETURN TO WORK DATE (MM/DD/YYYY)

IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.

HOSPITAL NAME ADMISSION DATE (MM/DD/YYYY) DISCHARGE DATE (MM/DD/YYYY)

ADDRESS

CITY STATE ZIP

PHYSICIAN'S NAME DEGREE SIGNATURE

PHONE NUMBER FAX NUMBER DATE (MM/DD/YYYY) STAMP

ADDRESS

CITY STATE ZIP

MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE

INDIVIDUAL PRACTITIONER'S S.S. NO. ALL OTHERS - EMPLOYER I.D. NO.

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:

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 for payment of a loss is subject to criminal and civil penalties.

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.

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. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant 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.

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.

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.

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, 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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Claim or Policy Number: _____

Name: _____ Doctor's Name: _____

Address: _____ Hospital's Name: _____

Birthdate: ____/____/____ Adm. ____/____/____ Disch. ____/____/____

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, 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 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 _____
(Signature of Claimant)

Date: _____
(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.