## Claims Made Easy

## CHUBB



HOW TO FILE YOUR CLAIM Please Follow the Simple Steps Below

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 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.
- 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**

Α

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.



CHUBB

**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**: If filing a critical illness 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 <a href="https://www.chubb.com/WorkplaceBenefitsClaims">www.chubb.com/WorkplaceBenefitsClaims</a>.

**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.

CBRCE-0722 (ESIS)



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

#### **IMPORTANT INSTRUCTIONS FOR FILING A CLAIM**

- 1. USE THIS CLAIM FORM FOR ACCIDENT, CRITICAL ILLNESS, DISABILITY OR HOSPITAL INDEMNITY CLAIMS.
- 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 PLEASE PRINT									CL	.AIN	ΛAΝ	IT S	TAT	ΓEΜ	EN	T (A	LL	CLA	λIM	IS)														
FIRST NAME													LA	ST N	AME	E								_		_							_	M.I.
E-MAIL ADDRESS (	(Your e-n	nail ad	dress w	vill be u	ıpdat	ted with	this i	nfori	matio	n if c	liffer	rent f	from	the e	mai	l on f	ile.)																	
PLEASE LIST OTHE	R NAMES	S THAT	YOU M	AY USI	E SUC	CH AS N	IAIDEI	N NA	ME, N	IICKN	IAME	E, ET	C. PF	RIMAI	RY P	HON	E								S	ECC	)ND/	ARY	РНО	NE				
MAILING ADDRESS	3																																	
CITY																								STA	TE		ZIP							
SOCIAL SECURITY	# (LAST	4 DIG	ITS)		ВІ	IRTH D	ATE (N	/M/D	D/YY	YY)					Н	IEIGH	IT (F	T/IN)		WEI	GHT	(LE	S)				Τ	MAI	LE	FEM	IALE			
	,		-,				/		/	T							Ì	T				Ì												
POLICY/CERTIFICA	ATF NUM	BFR(S	:)																															
			,																															
EMPLOYER'S NAM	IF																																	
LIMIFEOTER 3 NAME	_																											Т						
EMPLOYER'S ADD	DECC																																	
EWPLOTER'S ADD	KESS																																	
OUTV																																		
CITY																							r	STA	IE		ZIP							
																		_																
SECTION A-1									CL	.AIN	IΑΝ	AT S	ΙA	EM	EN.	T (A	CC	IDE	NT	CL	AII	VI)												
PLEASE COMPLET	E ALL A	PPLIC	ABLE S	ECTIO	NS B	ELOW	AND S	SUBN	MIT D	ocu	MEN	ITATI	ION T	o su	BST	TANT	ATE	cov	/ERI	ED S	ER\	/ICE	S CI	LAIN	ΙED	UND	ER'	YOUI	R PC	LICY				
COMPLETE FOR	AN A	CCII	DEN.	T CLA	λIM,	THEN	СОМ	PLE	TE S	SEC.	TIOI	N A-	3.																					
DATE OF ACCIDEN	IT (MM/D	D/YYY	Y)	INJ	IURIE	s sus	TAINE	D																										
	/																																	
PLEASE PROVIDE	AN EXA	CT DES	SCRIPT	ION OI	- WH	ERE Y	OU WE	RE \	WHEN	N AC	CIDE	NT (	occı	JRRE	D IN	ICLUI	DING	A DI	ETA	ILED	DE	SCF	IPTI	ION	OF \	ΝHΑ	T HA	APPE	NEC	то	YOU.			
SECTION A-2								CL	AIM	AN'	T S	TAT	ЕΜІ	ENT	(CI	RITI	CA	LIL	LN	ESS	s c	LA	IM)											
COMPLETE FOR	Δ CR	ITIC	:ΔΙΙ	ΙΙΝ	FS	Scu	ΔIM 7																											
DATE OF CRITICAL						RITICA									٠.																			
(MM/DD/YYYY)																																		
	/																																	
PLEASE PROVIDE	A COPY	OF TH	E PATH	IOLOG	Y RE	PORT (	OR TE	ST(S	) THA	AT C	ONFI	RM 1	THE D	DIAGI	IOS	IS AN	ID A	NYA	DDI	TION	IAL	DET	AILS	S, IN	CLU	DIN	G SY	MPT	ОМ	3.				

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										CL	AIN.	IANT	STA	ГЕМЕ	NT														
COMPLETE FOR EITHER ACCIDENT, CRITICAL ILLNESS OR DISABILITY CLAIM. NOT REQUIRED FOR HOSPITAL INDEMNITY. PRIMARY ATTENDING PHYSICIAN'S NAME																													
				•																									
ADDRESS																													
CITY																			STAT	ΓE	ZII	,							
PHONE NUMBER					FAX NU	JMBER	2			_			ı	NITIAL D	DATE	OF TRE	ATME	NT (M	IM/DI	D/YYYY	) LA	ST D	ATE (	OF T	REA	TME	NT (M	M/DD	/YYYY)
															1		/						1		/				
OTHER ATTENDIN	NG PHYSICIA	N'S OR	SPECIAI	LIST'S	NAME																_								
ADDRESS																													
CITY																			STAT	TF.	ZII	,							
																				_									
PHONE NUMBER					FAX NU	IMRER	•							ΝΙΤΙΔΙ Γ	DATE	OF TRI	FΔTMI	ENT (N	/M/D	D/YYY	Y) [ /	AST D	ΔTF	OF T	ΓRFΔ	TME	NT (M	M/DF	)/YYYY)
THORE NOMBER					Partic		Ì						ni.		/	J. 110	/			D, 111	., 		/	Ŭ		/			,,,,,
HOSPITAL NAME																									′				
TIOSFITAL NAME																													
HOSPITAL ADDRI	-00																										<u></u>		
HUSPITAL ADDRI	233																										Т		
OITY																				0.			710						
CITY																				5	TATE	T	ZIP						
					1=									1											<u> </u>				
PHONE NUMBER					FAX	IUMBE	=K							ADM	ISSIC	N DAT	E (MN	יוטטווי	YYYY	')		DISC		,	DAIL	(MIV	I/DD/Y	YYY)	
															,		1						,	/		_/			
	CLAIMANT STATEMENT (DISABILITY CLAIM)																												
SECTION A-4							C	LAII	MAN	IT S	TAT	EME	NT (E	ISAB	ILIT	Y CL	AIM)												
SECTION A-4		BILIT	Γ <b>Y</b> cL	AIM (	ONLY		C	LAII	MAN	IT S	TAT	EME	NT (E	DISAB	ILIT	Y CL	AIM)												
	R A DISA		Γ <b>Y</b> cL	AIM (	ONLY		•	LAII	MAN	IT S				DISAB						ЕМБ	PLOY	ER'S	CON.	TAC	T FA	X NU	IMBER	₹	
COMPLETE FO	R A DISA		<b>ΓΥ</b>	AIM (	ONLY		C	LAII	MAN	NT S										EMF	PLOY	ER'S	CON'	TAC	T FA	X NU	МВЕГ	?	
COMPLETE FO	R A <b>DISA</b> NTACT NAM		Γ <b>Y</b> CL	AIM (	ONLY		•	CLAII	MAN	IT S										EMF	PLOY	ER'S	M	IONT			IMBEF		
COMPLETE FO	R A <b>DISA</b> NTACT NAM		Γ <b>Y</b> CL	AIM (	ONLY			LAII	MAN	IT S										EMF	PLOY	ER'S	M						
COMPLETE FO	R A DISA	E						CLAII	MAN	IT S										EMF	PLOY	ER'S	M	IONT					
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION	R A DISA	E						LAII	MAN	IT S										EMF	PLOY	ER'S	M	IONT					
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION	NTACT NAM	CCUPATIO	ONAL DI	UTIES	JNDER 1		OLLOW	WING:	MAN	IT S			ER'S C	CONTAC	трн	ONE N				EMF			M	тиоі \$	THLY	EAF	RNING	S	
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION BRIEFLY DESCRI	ON DYOU INTERPENSATION	CCUPATIO	ONAL DI	UTIES	JINDER 1			WING:	MAN	IT S		IPLOY	ER'S C		SABI	ONE N			NO	EMF	IF	YES	TO A	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	i, WARD
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION BRIEFLY DESCRIPTION HAVE YOU, OR DO WORKERS' COMMACT?	ON  D YOU INTER PENSATION	ECUPATION TO, FI	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER			IF P O	YES LEAS R DEI	TO A	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATI BRIEFLY DESCRI HAVE YOU, OR DO WORKERS' COMM	ON  D YOU INTERPENSATION  HER ACCIDE	ECUPATION TO, FINTES	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER			IF P O	YES LEAS R DEI	TO A	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATION  BRIEFLY DESCRI  HAVE YOU, OR DO  WORKERS' COMMACT?  IF YOU HAVE OTH	ON  D YOU INTERPENSATION  HER ACCIDE	ECUPATION TO, FINTES	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER			IF P O	YES LEAS R DEI	TO A	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATION  BRIEFLY DESCRI  HAVE YOU, OR DO  WORKERS' COMMACT?  IF YOU HAVE OTH	ON  D YOU INTERPENSATION  HER ACCIDE	ECUPATION TO, FINTES	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER			IF P O	YES LEAS R DEI	TO A	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATI  BRIEFLY DESCRI  HAVE YOU, OR DI WORKERS' COMM ACT?  IF YOU HAVE OTH INSURANCE COM	ON  D YOU INTERPENSATION  HER ACCIDE	ECUPATION TO, FINTES	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER			IF P O	YES LEAS R DEI	TO A	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATI  BRIEFLY DESCRI  HAVE YOU, OR DI WORKERS' COMM ACT?  IF YOU HAVE OTH INSURANCE COM	ON  D YOU INTERPENSATION  HER ACCIDE	ECUPATION TO, FINTES	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER		STATE	IF P O	YES LEAS R DEI	TO A	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION BRIEFLY DESCRIPTION HAVE YOU, OR DO WORKERS' COMMACT? IF YOU HAVE OTH INSURANCE COM ADDRESS	ON  D YOU INTERPENSATION  HER ACCIDE	ECUPATION TO, FINTES	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER		STATE	IF P O	YES LEAS R DEI	TO A E SUI	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION BRIEFLY DESCRIPTION HAVE YOU, OR DO WORKERS' COMMACT? IF YOU HAVE OTH INSURANCE COM ADDRESS	ON  D YOU INTER  PENSATION  HER ACCIDE  IPANY NAME	ECUPATION TO, FINTES	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	OLLOW	WING:	ES		NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	'ES	ER		STATE	IF P O	YES LEAS R DEI	TO A E SUI	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION BRIEFLY DESCRI HAVE YOU, OR DO WORKERS' COMM ACT? IF YOU HAVE OTH INSURANCE COM ADDRESS	R A DISA NTACT NAM ON BE YOUR OC D YOU INTEN PENSATION HER ACCIDE IPANY NAME	ECUPATION TO STATE OF THE STATE	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	DLLOW SECUF	WING:	TES OMPA	LNYN	NO	IPLOY	ER'S C	CONTAC	SABII	ONE N	YES UUNT.	ER (IF NC	ONE,	STATE	IF P O	YES LEAS R DEI	TO A E SUI	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATI  BRIEFLY DESCRI  HAVE YOU, OR DI WORKERS' COMM ACT?  IF YOU HAVE OTH INSURANCE COM  ADDRESS  CITY  BENEFIT AMOUN	R A DISA NTACT NAM ON BE YOUR OC D YOU INTEN PENSATION HER ACCIDE IPANY NAME	ECUPATION TO, FI	DNAL DI	UTIES	JINDER 1 SO AC	CIAL S	DLLOW SECUF	WING:	TES OMPA	ANYN	NO	IPLOY	ST BI	TATE DISENSEITS	SABII S?	ONE N	YES DUNT.	ER (IF NC		STATE	IF P O	YES LEAS R DEI	TO A E SUI	S NY C	THLY OF TH	EAF HE P	RNING	S DING HE A	
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION BRIEFLY DESCRI HAVE YOU, OR DO WORKERS' COMM ACT? IF YOU HAVE OTH INSURANCE COM ADDRESS	R A DISA NTACT NAM ON BE YOUR OC D YOU INTEN PENSATION, HER ACCIDE IPANY NAME	ECUPATION TO, FI	DNAL DI LE A CL NO NESS DI	AIMU	JINDER T SO AC LITY INS	CIAL ST?	DLLOW SECUFI ICE, GI	VVE CO	TES OMPA	LNYN	NO	IPLOY	ST BI	CONTAC	SABII S?	ONE N	YES UUNT.	(IF NO	S\$	STATE	IFP PO	YES LEAS R DEI	TO A E SUI	NY CBMII	OF THE TACE	HE POPY	RECE	DING HE A'ED.	
COMPLETE FO EMPLOYER'S CO YOUR OCCUPATION BRIEFLY DESCRIPTION HAVE YOU, OR DO WORKERS' COMM ACT? IF YOU HAVE OTH INSURANCE COM ADDRESS CITY BENEFIT AMOUN TOTAL DISABIL	R A DISA NTACT NAM  ON  D YOU INTEN PENSATION HER ACCIDE IPANY NAME  T  WEEKLY  LITY: DATES WER	ECUPATION TO, FI	DNAL DI LE A CL NO NESS DI	LAIM U	JINDER T SO AC LITY INS	CIAL SET?	DLLOW SECUR ICE, GI	VVING: Y Y VVE CC	TES OMPA	LNYN	NO	IPLOY	ST BI	TATE DISENSE AND BE	SABIII S? ENEFI	ONE N	YES UUNT.	(IF NO	S\$	STATE	IFP O	YES LEAS R DEI	TO A E SUII	NY CBMIT	OF THE ACTION ARTIMATE	HE P P COPY IF RI	RECE	DING HE A'ED.	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATI  BRIEFLY DESCRI  HAVE YOU, OR DI WORKERS' COMMACT?  IF YOU HAVE OTH INSURANCE COM  ADDRESS  CITY  BENEFIT AMOUN  TOTAL DISABII BETWEEN WHAT	R A DISA NTACT NAM  ON  D YOU INTEN PENSATION HER ACCIDE IPANY NAME  T  WEEKLY  LITY: DATES WER	ECUPATION TO, FI	DNAL DI LE A CL NO NESS DI	LAIM U	JINDER 1 SO AC LITY INS	CIAL SET?	DLLOW SECUR ICE, GI	VVING: Y Y VVE CC	TES OMPA	LNYN	NO	IPLOY	ST BI	TATE DISENSE IN TIAL DIVEEN W	SABIII S? ENEFI	ONE N	YES UUNT.	(IF NO	S\$	STATE	IFP O	YES LEAS R DEI	TO A E SUII	NY CBMIT	OF THE ACTION ARTIMATE	HE P P COPY IF RI	RECE	DING HE A'ED.	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATI  BRIEFLY DESCRI  HAVE YOU, OR DI WORKERS' COMMACT?  IF YOU HAVE OTH INSURANCE COM  ADDRESS  CITY  BENEFIT AMOUN  TOTAL DISABII BETWEEN WHAT	R A DISA NTACT NAM ON BE YOUR OO D YOU INTER PENSATION HER ACCIDE IPANY NAME T WEEKLY LITY: DATES WER YYY)	ECUPATION FINE SECONDARION SEC	DNAL DI LE A CL NO NESS DI	LAIM U	JINDER 1 SO AC LITY INS	ANY E	DLLOW SECUR ICE, GI	VVING: Y Y VVE CC	TES OMPA	LNYN	NO	IPLOY	SI BI RESS, A	TATE DISENSE IN TIAL DIVEEN W	SABIII SAE	T AMO	VONT	(IF NO	\$ UAB	STATE	IFP O	YES LEAS R DEI	TO A E SUII	NY CBMIT	OF THE ACTION ARTIMATE	HE P P COPY	RECE	DING HE A'ED.	
COMPLETE FO  EMPLOYER'S CO  YOUR OCCUPATION  BRIEFLY DESCRI  HAVE YOU, OR DO  WORKERS' COMMACT?  IF YOU HAVE OTH INSURANCE COM  ADDRESS  CITY  BENEFIT AMOUN  TOTAL DISABIL  BETWEEN WHAT  FROM (MM/DD/YY)	R A DISA NTACT NAM ON BE YOUR OO D YOU INTER PENSATION HER ACCIDE IPANY NAME T WEEKLY LITY: DATES WER YYY)	ECUPATION FINE SECONDARION SEC	DNAL DI LE A CL NO NESS DI	LAIM U	JINDER 1 SO AC LITY INS	ANY E	DLLOW SECUR ICE, GI	VVING: Y Y VVE CC	TES OMPA	LNYN	NO	IPLOY	SI BI RESS, A	TIAL D	SABIII SAE	T AMO	VONT	(IF NO	\$ UAB	STATE	IFP O	YES LEAS R DEI	TO A E SUII	NY CBMIT	OF THE ACTION ARTIMATE	HE P P COPY	RECE	DING HE A'ED.	

2

#### **SECTION A-5** CLAIMANT STATEMENT (ACCIDENT & SICKNESS HOSPITAL INDEMNITY) — INSURED TO COMPLETE

## 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.	morado ricopital anno mar ale ione	g		a.o <b>c</b> , co.o	a., ca.e c,								
WHAT WAS THE REASON FOR YOUR HOSPITALIZATION?													
ARE YOU CLAIMING HOTEL LODGING BENE	EFITS FOR THIS HOSPITALIZATION? YES	NO	IF YES, PL	EASE SUBMIT THE	HOTEL RECEIPT(S).								
IS THIS HOSPITALIZATION DUE TO COMPLI		NO											
ARE YOU CLAIMING AN AMBULANCE BENE		NO											
ARE 100 CEAIMING AN AMBULANCE BENE		EASE SUBMIT	THE AMBULANCE	E RECEIPT(S).									
YES NO IF YOU ARE IF YOU ARE IF YOU ARE	CLAIMING ICU HOSPITALIZATION BENEFITS, CLAIMING NON-ICU HOSPITALIZATION BENEI CLAIMING EMERGENCY/URGENT CARE BENI CLAIMING REHABILITATION UNIT BENEFITS, CLAIMING ANY OTHER BENEFITS, COMPLETI	FITS, COMPLE EFITS, COMPL COMPLETE S	ETE SECTION I. LETE SECTION III.										
SECTION I	NON-IC	U HOSPITAL I	BENEFITS										
DATE OF ADMISSION TO A NON-ICU UNIT OF THE HOSPTIAL	DATE OF DISCHARGE TO A NON-ICU UNIT OF THE HOSPTIAL	NAME OF FACILITY											
ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)	СПҮ											
		STATE		ZIP									
SECTION II	ICU I	HOSPITAL BE	NEFITS										
DATE OF ADMISSION TO AN ICU UNIT OF THE HOSPTIAL	DATE OF DISCHARGE TO AN ICU UNIT OF THE HOSPTIAL	NAME OF FACILITY											
ADMISSION DATE (MM/DD/YYYY)	DISCHARGE DATE (MM/DD/YYYY)	CITY											
		STATE		ZIP									
SECTION III	EMERGEN	 NCY/URGENT	CARE BENEFITS										
EMERGENCY ROOM (ER) DATE (MM/DD/YYYY)	NATURE OF TREATMENT												
NAME OF FACILITY													
CITY				STATE	<u> </u>	ZIP							
URGENT DATE (MM/DD/YYYY) CARE , , ,	NATURE OF												
FACILITY / /	TREATMENT												
NAME OF FACILITY													
СІТУ				STATE	<b>E</b>	ZIP							
SECTION IV	REHABILI	TATION 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		OTHER BENE											
PROVIDE DETAILED DESCRIPTION OF OTHER TREA	IMENT OR BENEFITS YOU ARE CLAIMING FOR.	ADMISSION /	DATE (MM/DD/YY	ryy)	DISCHARGE DATE (MM/E	DD/YYYY)							
		NAME OF FACILITY											
		СПҮ											
		STATE		ZIP									

CBRCE-0722 (ESIS) Claimant

SECTION B EMPLOYER'S STATEMENT													
IF YOU ARE EMPLOYED, YOUR EMPLOYER MUST VERIFY YOUR DISABILITY BY COMPLETING SECTION C - EMPLOYER'S STATEMENT.  EMPLOYEE'S FIRST NAME  LAST NAME  M.I.													
EMPLOYEE'S FIRST NAME	LAST NAME M.I.												
CITY	STATE ZIP												
DUDIU DATE (MM/DDA	OLAMANUMDED (IF AVAILABLE)												
PHONE NUMBER BIRTH DATE (MM/DD/)	YYYY) CLAIM NUMBER (IF AVAILABLE)												
DATE LAST WORKED (MM/DD/YYYY) DATE RETURNED TO WORK (MM/DD/Y	YYY) MONTHLY EARNINGS												
	FULL TIME PART TIME												
POLICY NUMBER(S)													
FOLIOT HUMBER(3)													
EMPLOYEE'S OCCUPATION	DESCRIPTION OF PRIMARY OCCUPATIONAL DUTIES												
WAS THE OVER IN HIPTO ON THE 1979													
WAS EMPLOYEE INJURED ON THE JOB? HAS (OR WILL) A WORKERS' COMPENSATION	N CLAIM BEEN FILED FOR THIS DISABILITY? YES NO PAID? YES NO												
YES NO													
IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION	CARRIER, ALSO, SEND REPORT OF INITIAL INJURY.												
NAME													
NAME													
ADDRESS													
CITY	STATE ZIP												
PHONE NUMBER													
FRONE NUMBER													
PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)													
H H M M	H H M M												
SITTING PER DAY WALKING PER DAY C	CLIMBING STAIRS/LADDERS PER DAY DRIVING PER DAY												
LIFTING: LESS THAN 10 LBS 10 TO 20 LBS MORE THAN 20 LB	SS STOOPING/BENDING: NONE SELDOM FREQUENT												
TOTAL DISABILITY:	PARTIAL DISABILITY:												
BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES?	BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES?												
FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)	FROM (MM/DD/YYYY) THROUGH (MM/DD/YYYY)												
DURING PARTIAL DISABILITY, WHAT PERCENTAGE OF PRE-DISABILITY INCOME DID/WILI	L THE EMPLOYEE RECEIVE?%												
DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)													
EMPLOYER CONTACT NAME CONTACT'S I	POSITION DATE (MM/DD/YYYY)												
SIGNATURE	PHONE NUMBER FAX NUMBER												
<del></del>	TAX TOMBER												

SECTION C					A	TTE	NDING			AN'S	STA	TEME	NT												
PATIENT'S FIRST NA	ME						LAS	T NAM	E														M.I.		AGE
ADDRESS																									
CITY															ST/	ATE		IP.							
															31/	41E		-IIF							
			DIAGNOSIS (I	DESCRIBI	E COM	PLICA	TIONS,	IF ANY	)																
NATURE AND ORIGI	N OF:	SICKNESS	3																						
		INJURY																							
WHEN DID SYMPTOM (MM/DD/YYYY)	MS FIRST AP	PEAR OR A	CCIDENT HAPPI		EN DID		NT FIR	ST CO	NSULT	YOU	FOR 1	HIS C	ONDITI	ION?		CKNE		VHEN	WAS	CONE	OITIO	FIRS	ST DIA	GNO	SED?
/	/				/	,	/								(IIIIII)	<i>J J J</i>	/		/						
INDICATE THE DATE (MM/DD/YYYY)	AND TYPE O	OF DIAGNO	STIC TEST USED	TO DIAG	NOSE	CURR	ENT C	ONDITIO	ON. IF	MORI	E TEST	rs wei	RE PER	RFORI	MED,	PLEA	SEIN	ICLU	DE SU	JPPOR	TING	DOC	UMEN	TATIC	ON.
	/																								
HAS PATIENT EVER OR SIMILAR CONDIT		YES	NO (IF	"YES", S	STATE V	VHEN /	AND DI	ESCRIE	BE.) (M	M/DD	/YYYY	)													
DESCRIBE ANY OTH	ER MEDICAL	CONDITIO	N IMPACTING TH	IE PATIEI	NT.																				
NATURE OF SURGIC DATE (MM/DD/YYYY)		ETRICAL P	PROCEDURE(S),	IF ANY. (C	DESCRI	BE FU	ILLY)													OPEN	I OP 1	21.09	FD P	:טווכ	TION
/ / / / / / / / / / / / / / / / / / /	/																			OPEN			LOSE		N
			NAME OF FACILITY																						
GIVE DATES OF TRE	ATMENT AN		OF TREATMENT	OTHER T		JRGIO	CAL.																		
	/	/		TREAT		5)																			
	/	/																							
	/	/		NAME (																					
EMERGENCY DA	TE (MM/DD/Y	YYY)		NATUR TREATI																					
	/	/		NAME (	OF																				
URGENT DA	TE (MM/DD/Y	YYY)		NATUR										+	+	+			_		+			_	
CARE FACILITY	1	/		TREAT	MENT																				
				FACILIT																					
PLEASE STATE RES	TRICTIONS F	PLACED ON	I PATIENT FOR A	NY DISAE	BILITY 1	THAT	HAS BE	EN INC	DICATE	D.															
IS THE PATIENT STIL UNDER YOUR CARE	? (UNABLE	TO WORK)	?						LED	(	ONLY	ONG V	TO WC	ORK P				ERFO	RM P	ARTIA	L JOE	DUT	IES)?		
vee NO		M/DD/YYYY ,	)	THR	ROUGH	(MM/E	DD/YYY	Y)			FROM	(MM/D	D/YYY	Y)				THE	ROUG	H (MM	/DD/Y	YYY)			
		/			/		/					/		/						1					
IF PATIENT DISABLE				•				ORK D	ATE?		RET	URN TO	O WOR	RK DA	TE (M	M/DD	/YYY	Y)							
YES NO			TE THE RETURN								1000	/		/	5000				2011			/a.a.a./		200	
IF HOSPITALIZED, G HOSPITAL NAME	IVE NAME A	ND ADDRES	SO OF HOSPITAL	AND DAI	IES OF	CONF	INCINE	NI.			ADIVIS	SSION	DAIE	(IVIIVI/D	י זי/ט	11)			ЗСПА	ARGE I	JAIE	(IVIIVI/I	י זי/טע	11)	
												/		/						/		/			
ADDRESS																									
CITY															STA	ATE	7	IP.							
PHYSICIAN'S NAME						D	EGREE			T	SIG	GNATU	RE												
PHONE NUMBER			FAX NUI	MBFR						DAT	TE (MIN	I/DD/Y	YYY)					STAI	MP						
TOWNER TOWNER			TAK NO								_ (,,,,,,	/	/					- 171							
ADDRESS			·																						
CITY															STA	ATE		IP.							
INDIVIDUAL PRACTI	TIONER'S S	S. NO.	MUS	T BE FU	RNISHE	D UN	DER AL	_				109 OF OYER			DDE										



#### 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.

#### 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.

**RHODE ISLAND:** 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.

**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.

**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.

**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.

**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 best of my knowledge and belief. I have read the appreserves the right to require or obtain further information.	plicable fraud notification stat	tement. I also understand the Company
XCLAIMANT'S SIGNATURE	DATE	PLEASE PRINT NAME
I signed on behalf of the claimant, as	attach a copy of the docume	(relationship). If you are the nt 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.



## 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.

#### **Chubb Workplace Benefits**

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



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	 	 	 	 	 	 	_										





## **AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

Claim or Policy Number:											
Name:		Doctor's Name:									
Address:		Hospital's N	lame:								
Birthdate:///	_	Adm		Disch//							
information to be obtained sl consumer reporting agency, loss or condition being evalua-	to obtain necessary medical inform hall include information from any Pr any other insurance company, or thated. I further authorize CHUBB to re on about me for purposes of proce	rescription Drug Dat ne "MIB" (Medical In ely on this authorizat	abase, all heali formation Bure tion for two year	th care providers, employer, au), which is relevant to my rs, or as otherwise permitted							
The information to be disclos	sed may include but is not limited to	:									
History of Present Illness Operative Reports Daily Doctor's Notes X-Ray Reports	Consultant's Report Pathology Reports Past Medical History Blood/Toxicology	Discharge Su Laboratory R Previous Adr	Results								
The information is needed fo	r the following purpose(s): Evaluation	on and processing o	of my insurance	claim							
	ation released by this authorization hol/drug abuse and past medical his		formation conc	erning treatment of physical							
without any express revocat so, I must present a written	t of the above stated purposes, the ion. I understand and I have the rigrevocation to CHUBB. I understand with the right to contest a claim understand.	ght to revoke this at I that revocation will	uthorization at a not apply to m	any time, and in order to do by insurance company when							
information carries with it the	ect the information disclosed pursus potential for re-disclosure and the nrollment or eligibility of benefits ma	information may no	t be protected I	by the federal confidentiality							
X		Dat	te:								
(Signature	of Claimant)			(Must be filled in)							
X											
(Signature of Page 1)	arent or Guardian)	(Rel	lationship to Pa	tient if Signed by Guardian)							

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

CBRCE-0722 (ESIS) 10