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

IMPORTANT INSTRUCTIONS FOR FILING A CLAIM

1. USE THIS CLAIM FORM FOR ACCIDENT, CRITICAL ILLNESS, DISABILITY OR HOSPITAL INDEMNITY CLAIMS.
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 CLAIM)

COMPLETE FOR A **CRITICAL ILLNESS** CLAIM, THEN COMPLETE SECTION A-3.

DATE OF CRITICAL ILLNESS DIAGNOSIS (MM/DD/YYYY)	CRITICAL ILLNESS 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, CRITICAL ILLNESS** OR **DISABILITY** CLAIM. NOT REQUIRED FOR HOSPITAL INDEMNITY.

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 NO

SOCIAL SECURITY ACT? YES NO

STATE DISABILITY BENEFITS? YES NO

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

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.

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.

CITY | STATE | ZIP

PHONE NUMBER | BIRTH DATE (MM/DD/YYYY) | CLAIM NUMBER (IF AVAILABLE)

DATE LAST WORKED (MM/DD/YYYY) | DATE RETURNED TO WORK (MM/DD/YYYY) | FULL TIME ☐ PART TIME ☐ | MONTHLY EARNINGS $

POLICY NUMBER(S)

EMPLOYEE'S OCCUPATION | DESCRIPTION OF PRIMARY OCCUPATIONAL DUTIES

WAS EMPLOYEE INJURED ON THE JOB? YES ☐ NO ☐

HAS (OR WILL) A WORKERS' COMPENSATION CLAIM BEEN FILED FOR THIS DISABILITY? YES ☐ NO ☐ PAID? YES ☐ NO ☐

IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION CARRIER. ALSO, SEND REPORT OF INITIAL INJURY.

NAME

ADDRESS

CITY | STATE | ZIP

PHONE NUMBER

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

SITTING H H M M PER DAY | WALKING H H M M PER DAY | CLIMBING STAIRS/LADDERS H H M M PER DAY | DRIVING H H M M PER DAY

LIFTING: ☐ LESS THAN 10 LBS ☐ 10 TO 20 LBS ☐ MORE THAN 20 LBS | STOOPING/BENDING: ☐ NONE ☐ SELDOM ☐ FREQUENT

TOTAL DISABILITY:
BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES?

FROM (MM/DD/YYYY) | THROUGH (MM/DD/YYYY)

PARTIAL DISABILITY:
BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES?

FROM (MM/DD/YYYY) | THROUGH (MM/DD/YYYY)

DURING PARTIAL DISABILITY, WHAT PERCENTAGE OF PRE-DISABILITY INCOME DID/WILL THE EMPLOYEE RECEIVE? _____ %

DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)

EMPLOYER CONTACT NAME | CONTACT'S POSITION | DATE (MM/DD/YYYY)

SIGNATURE | PHONE NUMBER | FAX NUMBER

SECTION C — ATTENDING PHYSICIAN'S STATEMENT

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

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

X_____ _____ _____

CLAIMANT'S SIGNATURE | DATE | PLEASE PRINT NAME

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

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

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

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

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

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

Print Name

Signature

E-mail Address

Date

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Claim or Policy Number:_____

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

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

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