CHUBB

Critical Illness Claim Form

IMPORTANT NOTICE: *Written notice of claim must be provided within 90 days of the loss. Written proof of loss must be provided within 90 days after the date of loss. If it cannot be provided within that time period, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted more than one year from the date it was otherwise required.*

Please mail your completed Claim Form with itemized bills and receipts to:
(to expedite your claim, please fax it with readable receipts)

Chubb USA
PO Box 5124
Scranton, PA 18505-0556

(800) 336 0627 Inside USA
(302) 476 6194 Outside USA
(302) 476 7857 Fax
diane.basa@chubb.com

Thank you for notifying us of your claim. Please complete ALL questions. If any question is not applicable, please state N/A.

Policyholder/Insured Information

Policyholder: _____ Policy Number: _____

Insured's Name: _____ Date of Birth: _____

Home Address: _____

Please provide telephone and facsimile numbers, with country and city codes.

Home #: _____ Work #: _____ Fax #: _____

E-mail: _____

Full description of disease you are claiming: _____

_____

Have you had this or a similar condition in the past? ☐ Yes ☐ No

If yes, state the nature of the condition, dates of treatment, and names and addresses of treating doctors, hospitals, and clinics: _____

_____

_____

Give exact date when illness began or injury occurred: _____

Date you first consulted a physician for this condition: _____

Provide names, addresses and dates of confinement for all hospitals: _____

_____

_____

Provide name, address and telephone # for all attending physicians: _____

_____

_____

Provide name, address and telephone # for usual family physician: _____

_____

Please provide names and addresses of all treating physicians and hospitals during the past five (5) years and the reason and date of treatment. May attach additional page for more space:

_____

_____

Attending Physician's Statement

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Diagnosis: _____

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

If yes, please explain: _____

When did symptoms first appear?: _____

When did patient first consult you for this condition?: _____

Has patient ever had same or similar condition? ☐Yes ☐No

If yes, please explain: _____

Nature of surgical procedure: _____

Hospital name: _____ ☐Inpatient ☐Outpatient

What other services, if any, did you provide to patient? (itemize giving dates and fees):

_____

_____

Is patient still under your care for this condition? ☐Yes ☐No

If no, give date services terminated: _____

Remarks: _____

_____

Name (Attending Physician) – Please Print

_____ Phone No: _____

Address: _____

Signature of Attending Physician:

_____ Dated: _____

Signature of Insured or Authorized Representative

_____ Dated: _____

Authorization and Assignment of Benefits

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be as valid as the original.

I understand that I or my authorized representative may request a copy of this authorization.

I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorized Representative: _____

Relationship (if other than Insured): _____ Dated: _____

Address: _____

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

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.

Florida
Any person who knowingly and with intent in 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.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process 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 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 and subjects such person to criminal and civil penalties.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.