

Claims Made Easy

CHUBB®



HOW TO FILE YOUR CLAIM - Please Follow the Simple Steps Below

1. Download the claim form. Complete sections based on the claim type

For Accident Claims

1. Complete Sections A, B and D.
2. Have your physician complete Section G.

For Critical Illness Claims

1. Complete Sections A, C and D.
2. Have your physician complete Section G.

For Disability Claims

1. Complete Sections A, D and E.
2. Have your employer complete Section F.
3. Have your physician complete Section G.

2. Review the Fraud Notification for your state located on the fifth or sixth page.
3. Sign and date the claim form on the signature line provided at the end of the Fraud Notification page of the claim form. If you do not sign the Fraud Notification page, we cannot accept your claim submission.
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 (Claimant 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: 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 and the level of severity.



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.



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/us-en/claims/chubb-workplace-benefits.aspx.

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.

Third page (Employer completes)

If you are employed outside the home, your employer must verify your disability by completing Section F - Employer's Statement.

Fourth page (Doctor completes)

Your primary physician must complete Section G - Attending Physician's Statement in its entirety. Failure to make sure that your physician fills in all necessary information on the claim form may cause delays in the processing of 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

IMPORTANT INSTRUCTIONS FOR FILING A CLAIM

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

SECTION A				CLAIMANT STATEMENT			
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		HEIGHT (FT/IN)	WEIGHT (LBS)	MALE	FEMALE
<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
POLICY/CERTIFICATE NUMBER(S)							
EMPLOYER'S NAME							
EMPLOYER'S ADDRESS							
CITY						STATE	ZIP

SECTION B		CLAIMANT STATEMENT	
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 D.			
DATE OF ACCIDENT		INJURIES SUSTAINED	
<input type="text"/>		<input type="text"/>	
PLEASE PROVIDE AN EXACT DESCRIPTION OF WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF WHAT HAPPENED TO YOU.			

SECTION C		CLAIMANT STATEMENT	
COMPLETE FOR A CRITICAL ILLNESS CLAIM, THEN COMPLETE SECTION D.			
IF FILING FOR CRITICAL ILLNESS BENEFITS, PLEASE ATTACH A COPY OF THE PATHOLOGY REPORT OR TEST(S) THAT CONFIRM THE DIAGNOSIS AND THE SEVERITY OF THE CONDITION.			
DATE OF DIAGNOSIS FOR CURRENT SICKNESS		SICKNESS DIAGNOSIS IF KNOWN	
<input type="text"/>		<input type="text"/>	
PLEASE PROVIDE 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 D CLAIMANT STATEMENT

COMPLETE FOR EITHER **ACCIDENT, CRITICAL ILLNESS** OR **DISABILITY** CLAIM

FIRST ATTENDING PHYSICIAN'S NAME

ADDRESS

CITY STATE ZIP

PHONE NUMBER FAX NUMBER INITIAL DATE OF TREATMENT LAST DATE OF TREATMENT

SECOND ATTENDING PHYSICIAN'S NAME

ADDRESS

CITY STATE ZIP

PHONE NUMBER FAX NUMBER INITIAL DATE OF TREATMENT LAST DATE OF TREATMENT

HOSPITAL NAME

HOSPITAL ADDRESS

CITY STATE ZIP

PHONE NUMBER FAX NUMBER ADMISSION DATE DISCHARGE DATE

SECTION E CLAIMANT STATEMENT

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 FILED A CLAIM UNDER THE FOLLOWING: WORKERS' COMPENSATION ACT? SOCIAL SECURITY ACT? STATE DISABILITY BENEFITS? 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? PARTIAL DISABILITY: BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?

DATE LAST WORKED DATE RETURNED TO WORK

PLEASE HAVE YOUR EMPLOYER COMPLETE AND SIGN SECTION F - EMPLOYER'S STATEMENT FOUND ON THE NEXT PAGE.

SECTION F

EMPLOYER'S STATEMENT

IF YOU ARE EMPLOYED OUTSIDE THE HOME, YOUR EMPLOYER MUST VERIFY YOUR DISABILITY BY COMPLETING SECTION C – 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 checked="" type="checkbox"/> PART TIME <input checked="" type="checkbox"/>	MONTHLY EARNINGS \$,
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POLICY NUMBER(S)

EMPLOYEE'S OCCUPATION	DESCRIPTION OF OCCUPATION'S PRIMARY DUTIES
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WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	PAID? YES <input checked="" type="checkbox"/> NO <input checked="" 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 <input checked="" type="checkbox"/> PER DAY	WALKING <input checked="" type="checkbox"/> PER DAY	CLIMBING STAIRS/LADDERS <input checked="" type="checkbox"/> PER DAY	DRIVING <input checked="" type="checkbox"/> PER DAY
LIFTING: <input checked="" type="checkbox"/> LESS THAN 15LBS	<input checked="" type="checkbox"/> 15 TO 45LBS	<input checked="" type="checkbox"/> MORE THAN 45LBS	STOOPING/BENDING: <input checked="" type="checkbox"/> NONE <input checked="" type="checkbox"/> SELDOM <input checked="" type="checkbox"/> FREQUENT

TOTAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES?	PARTIAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES?
FROM THROUGH MM DD YYYY MM DD YYYY	FROM THROUGH MM DD YYYY MM DD YYYY

DURING PARTIAL DISABILITY, DID/WILL EMPLOYEE RECEIVE 75% OR MORE OF HIS PRE-DISABILITY INCOME? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	IF NO, WHAT PERCENTAGE? _____ %
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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 G

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: <input checked="" type="checkbox"/> SICKNESS <input checked="" type="checkbox"/> INJURY	DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)
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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
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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 <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	(IF "YES", STATE WHEN AND DESCRIBE.) MM DD YYYY
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HOW DID CONDITION ORIGINATE?	DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.
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NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)		OPEN OR CLOSED REDUCTION
DATE MM DD YYYY	PROCEDURE	OPEN <input checked="" type="checkbox"/> CLOSED <input checked="" type="checkbox"/>
	NAME OF FACILITY	

GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.		
OFFICE	DATE MM DD YYYY	NATURE OF TREATMENT(S)
	MM DD YYYY	
	MM DD YYYY	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

IS THE PATIENT STILL UNDER YOUR CARE?	HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?	HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	FROM THROUGH MM DD YYYY MM DD YYYY	FROM THROUGH MM DD YYYY MM DD YYYY

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

IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE?	RETURN TO WORK DATE
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> (IF "YES", GIVE RETURN TO WORK DATE.)	MM DD YYYY

IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.	ADMISSION DATE	DISCHARGE DATE
HOSPITAL NAME	MM DD YYYY	MM DD YYYY

ADDRESS

CITY STATE ZIP

PHYSICIAN'S NAME	DEGREE	SIGNATURE
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PHONE NUMBER	FAX NUMBER	DATE MM DD YYYY	STAMP
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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.

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.