CHUBB®

Critical Illness Insurance
Insured's Statement
(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ Claim#: _____

Soc. Sec. No. _____-_____-_____

Date of Birth ____/____/____ (MM/DD/YY) Marital Status _____

Insured's Address _____

Phone No. (H)_____ Phone No. (W)_____

Phone No. (C)_____ Policy Number (Required) _____

Insured's Email Address: _____

DEPENDENT INFORMATION

Dependent Name _____ Relationship to Insured _____

Date of Birth ____/____/____ (MM/DD/YY) Marital Status _____

Soc. Sec. No. _____-_____-_____

CLAIM INFORMATION

Please describe in detail the nature of your current condition (attach separate sheet if needed):

_____

_____

Date the symptom of this condition first appeared ____/____/____ (MM/DD/YY)

Date of first treatment ____/____/____ (MM/DD/YY)

Did you ever suffer from the same or a similar condition? **YES / NO**

If yes, please describe _____

Please provide the name and address of the initial treating physician:

_____

Are you currently being treated by a Specialist? **YES / NO**

If yes, please provide name and address of that Specialist: _____

_____

Please list the names and addresses of all treating physicians and hospitals:

Name	Address	City/ST	Phone	Comments

Benefit Amount Claimed: $_____

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, Broadspire Services, Inc., a subsidiary of Crawford & Company, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Insured or authorized person) _____

DATE ____/____/____ (MM/DD/YY)

IMPORTANT NOTICE

Notice to Alaska Claimants: 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.

Notice to Arizona Claimants: 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.

Notice to Arkansas Claimants: 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.

Notice to California Claimants: For your protection, California law requires the following to appear on this form: 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.

Notice to Colorado Claimants: 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 many 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.

Notice to Delaware Claimants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

Notice to District of Columbia Claimants:
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.

Notice to Florida Claimants: 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.

Notice to Idaho Claimants: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information, is guilty of a felony.

Notice to Indiana Claimants: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Notice to Kentucky Claimants: 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.

Notice to Maine Claimants: 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.

Notice to Maryland Claimants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Claimants: A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

Notice to New Hampshire Claimants: 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.

Notice to New Jersey Claimants: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Notice to New Mexico Claimants: 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.

Notice to New York Claimants: 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.

Notice to Ohio Claimants: Any person who, with the 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.

Notice to Oklahoma Claimants: 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.

Notice to Oregon Claimants: Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company's acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company's acceptance of risk, may be guilty of a fraudulent act, which is a crime.

Notice to Pennsylvania Claimants: 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.

Notice to Rhode Island Claimants: 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.

Notice to Virginia Claimants: 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.

Notice to Claimants in all other states: Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

CHUBB®

Critical Illness Claim

Attending Physician's Statement

(Please print – Attach separate sheet if additional space required)

PATIENT INFORMATION

Patient's Name_____ Soc. Sec. No. _____-_____-_____

Date of Birth ____/____/____ (MM/DD/YY) Marital Status _____

Patient's Address_____

Phone No. (H)_____ Phone No. (W)_____

Insured's Name: _____ Patient's relationship to Insured: _____

Insured's Email Address: _____

Policy Number (Required) _____

Are you related by blood or marriage to the Insured? **YES NO**

CLAIM INFORMATION

Are you the patient's primary treating physician? **YES NO**

If not, please provide the name and address of primary treating physician:

_____

Please describe in detail the nature of the patient's illness, including all applicable ICD codes:

_____

_____

_____

Date of first symptom: ____/____/____ (MM/DD/YY)

Date of first treatment: ____/____/____ (MM/DD/YY)

Was the patient hospitalized? **YES / NO**

If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

Hospital Name	Address	Admission Date	Discharge Date

Did the patient have any prior injury or illness that contributed to the patient's present condition? **YES / NO** If yes, please describe:

_____

_____

_____

Were any surgical procedures performed? **YES / NO**
If yes, please list all procedures, including applicable CPT codes and dates performed:

_____

_____

_____

What are the patient's current subjective symptoms?

_____

_____

_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)?

_____

_____

_____

Was the patient seen by any other physician? **YES / NO**

If yes, please list the names and addresses of all other physicians:

_____

_____

_____

_____

_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____

Phone No. (_____)_____

Address: _____

_____

_____

Specialty: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____

DATE ____/____/____ (MM/DD/YY)