CHUBB

Crawford®

Accidental Death

Claimant's Statement

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

INSURED INFORMATION

Insured's Name_____ Date of Birth ___/___/___ Marital Status _____

Insured's Last Address_____

Name and address of last employer _____

Policy Number (Required)_____ Insured's Occupation (at time of death) _____

Did the insured have any other accident or life insurance? _____ If yes, please list all companies, policy numbers and insurance amounts:_____

CLAIM INFORMATION

Date of accident _____/_____/_____ Time and place accident occurred_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ If so, how? _____

Please describe the cause of the Insured's death: _____

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

_____

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies: _____

Was an autopsy performed?_____ If yes, please provide name and address of Medical Examiner_____

Was a coroner's inquest held? _____If yes, what was the determination? _____

CLAIMANT INFORMATION

Claimant's Name_____ Age_____ Relationship to Insured_____

Claimant's Address_____ Phone No. (H)_____

_____ Phone No. (W)_____

Claimant's email address_____ Phone No. (C) _____

In what capacity are you making this claim? _____ Beneficiary _____ Executor* _____ Administrator* _____ Guardian* _____Trustee* _____Assignee*

*Please provide a certified copy of all documents supporting your authority (e.g., Letters Testamentary, Letters of Administration, etc.)

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, 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 (Claimant or authorized person) _____ DATE ___/___/___