MAIL TO:
Administrative Concepts, Inc.
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
www.visit-aci.com

Arch Insurance Company

Proof of Claim- Accidental Death

(No Liability is admitted by the issue of this form)

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Statement of Beneficiary

Insured	Certificate number(s)

Facts concerning deceased

Full Name:	
Last Name First Name M.I.	Social Security #

Home Address:

and Street City/Town State Zip Code

Date of Birth:	Place of Birth:	Social Security Number:
Occupation:	Name of Employer:	

Employer's Address:

Beneficiary

Name of Beneficiary:		
Last Name First Name M.I.	Social Security #	Date of Birth:

Address:

and Street City/Town State Zip Code

Relationship to Insured:	Telephone number:

Complete for all claims

Date of Accident:	Place accident occurred:

Describe how accident occurred:

Did the accident happen at work: Yes ☐ No ☐ Has a claim or will a claim be filed under worker's compensation? Yes ☐ No ☐

Name of worker's compensation carrier:

Address:

and Street City/Town State Zip Code

To be completed if Death resulted from motor vehicle accident

Type of Vehicle:	Registered Owner	Was deceased the driver? Yes ☐ No ☐

Use of vehicle: ☐ Business ☐ Pleasure ☐ Business and Pleasure

Name of law enforcement agency investigating accident:

Address:

and Street City/Town State Zip Code

To be completed on all claims

Was an inquest held: Yes ☐ No ☐ If "yes", complete the following and attach a copy of the proceedings and verdict

Name of court holding hearing:

and Street City/Town State Zip Code

Was an autopsy conducted Yes ☐ No ☐ If "yes", complete the following and attach a copy of the report

Name of person conducting autopsy:	Title:

Address:

and Street City/Town State Zip Code

First physician attending deceased after injury

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	

Other physicians attending deceased after injury

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	

Previous medical history

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Medical Condition:	Dates of Treatment:
Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Medical Condition:	Dates of Treatment:

Other Insurance on life of deceased

Company name:	Amount:
Address:	
# and Street / City/Town / State / Zip Code	
Company name:	Amount:
Address:	
# and Street / City/Town / State / Zip Code	

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

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 a 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 beneficiary/ claimant	Dated
Address:	

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ARKANSAS, LOUISIANA AND NEW MEXICO RESIDENTS: 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 COLORADO RESIDENTS: 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.

NOTICE TO DISTRICT OF COLUMBIA RESIDENTS: 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 RESIDENTS: 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 in the third degree.

NOTICE TO KENTUCKY RESIDENTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance 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 RESIDENTS: It is a crime to 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 NEW JERSEY RESIDENTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK RESIDENTS: 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 RESIDENTS: 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.

NOTICE TO OKLAHOMA RESIDENTS: 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 PENNSYLVANIA RESIDENTS: Any person who knowingly and with the 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 PUERTO RICO RESIDENTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps, or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON RESIDENTS: 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.