STARR
INDEMNITY & LIABILITY

ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM FORM

IMPORTANT INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

To ensure expeditious claim processing, the attached claim forms need to be fully completed and the following instructions must be adhered to. Each claim will be evaluated based on the terms and conditions of the insurance policy. The Insurance Company reserves the right to request additional information and/or documents to help us make this evaluation. The acceptance of these forms by the Insurance Company is not an admission of coverage under an insurance policy.

Part I – Claimant's Statement

To be completed by claimant or beneficiary in its entirety

Please furnish any newspaper accounts or other pertinent information regarding the claim.

Part II – Attending Physician's Statement (required for accidental dismemberment claims)

Attending physician must complete this form. Any expense for completion of the form is the responsibility of the claimant.

Miscellaneous – All Claims

Required documents other than the claim form

- Certified true copy of death certificate (Accidental Death Claim)
- Police Report (if applicable)
- Autopsy/Post Mortem & Toxicology report (if applicable)

If the claim proceeds are payable to an estate, Part I must be completed by the executor or administrator of the estate. A copy of the court document appointing the executor or administrator must be attached to this form.

If any designated beneficiary is a minor, Part I must be completed by the custodian or guardian. A copy of the court document appointing the guardian or a similar document must be attached to this form.

For a foreign death, the official death certificate and the Report of the Death of an American Citizen Abroad form must be attached to the claim form.

Helpful information for submitting claims and expediting payment.

- A fully completed Claim Form is required. Claims submitted with incomplete information will not be paid pending receipt of the missing information.

- The acceptance of a claim form by an insurance company is not an admission of coverage. We reserve the right to obtain additional information, as needed, to evaluate the claim.

Mail to:
Administrative Concepts, Inc
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1082
www.visit-aci.com

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ACCIDENTAL DEATH & DISMEMBERMENT CLAIM FORM

PART I– **Claimant's Statement:** Accidental Death & Dismemberment Only. Claim Form for INSURED or DEPENDENT

***INSTRUCTIONS**: Complete this form if you are applying for death or dismemberment benefits due to an Accident.*
If a question does not apply, please mark "N/A".

EMPLOYER NAME:

Name of Insured :		**Social Security Number**
Name of Deceased or Injured (if different from above)		Address of Insured/Deceased:
Relationship to Employee: ☐ Spouse/Domestic Partner ☐ Child	Date of Birth:	

On what date did the accident happen? _____ Where did the accident happen? City _____ State _____
Please describe all injuries received.

Did accident result in death? ☐ Yes ☐ No If "Yes", on what date? _____

If claim is for a dependent, is the insured married? ☐YES ☐NO	If claim is for a dependent, does the insured have children? ☐YES ☐NO If Yes, provide names and ages of children:

Describe in detail how the accident occurred.

Name and address of law enforcement agency involved (Please submit copy of Police Accident Report).

List name/address/phone # of all physicians consulted for this injury/death.

List name/address/phone # of all hospitals consulted.

Did the deceased/injured have any chronic disease or physical defect or deformity? ☐Yes ☐No If "Yes", describe in detail:

Was autopsy performed? ☐ Yes ☐ No If "Yes", provide name/address/telephone number of coroner, if known		Was an inquest held? ☐ Yes ☐ No If "Yes",verdict?	
Name of Beneficiary	Address	Telephone Number	Social Security Number:

Your date of birth _____ In what capacity are you making claim? _____
(Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)

Your address _____ and

Telephone number _____ (if different from beneficiary).
Your relationship to deceased or injured _____ Your Social Security Number _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the deceased or insured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV and alcohol/drug records to release all such records in their entirety to AXIS Insurance Company, and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time be sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier. I understand that by signing this form I may be authorizing the use and disclosure of my confidential protected health information to AXIS Insurance Company.

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.

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE

:

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PART II – **Attending Physician's Statement**
Required for all accidental dismemberment claims.

Attending physician must complete this form. Any expense for completion of the form will be paid by claimant.				
Name of Patient:	Date of Birth:	Address (Street, City, State, Zip Code):		
When did accident happen: (Month, Day, Year)	When did patient first consult you for this condition?: (Month, Day, Year)			
Nature of injury: Please explain in complete detail, including all diagnoses, any dismemberment or loss of use; the cause or incident causing the injury, and all affected body parts.				
If injury resulted in severance of a body part, please indicate the precise location of the severance:				
Did injury result in the total and irrecoverable loss of hearing in both ears? □Yes □No Date of loss:				
Did the injury result in: □ Paralysis	□ Quadriplegia	□ Paraplegia	□ Hemiplegia	
In your opinion, was any disease, infection, bodily or mental infirmity an underlying cause in the loss(es) indicated above?				
If an operation is contemplated, give approximate date and nature of the operation:				
In your opinion, did the loss(es) result from any self-inflicted injury or attempted self-destruction? □ Yes □ No				
If injury resulted in loss of sight, was the loss total and irrecoverable? □ Yes □ No Which eye was injured? □ Right □ Left Was the eye removed? □ Yes □ No On what date did the total and irrecoverable loss occur? If the loss of sight is partial, but irrecoverable, please state amount of vision in each eye with Snellen notations, or Jaeger scale, if pertinent.				
Uncorrected O.D.	O.S.	Corrected O.D.	O.S.	Date of Examination
Do you believe vision can be restored in whole or in part by treatment or operation? □ Yes □ No				
Was patient confined to a hospital? □Yes □No If "Yes", give name and address of hospital and dates of confinement:				

Treatment				
Date of first visit	Dates of Subsequent Visits			
Is patient still under your care for this condition? □ Yes □ No				
If discharged, give date of discharge:				
Signature of Attending Physician	Physician's Name (Please Print)	Degree	Telephone	Date
Street Address:	City or Town		State or Province	Zip Code