# 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

CHUBB

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Telephone 1-866-445-8874 • Fax 1-312-351-7120

**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 |
|---|---|---|---|---|---|
| | MM DD YYYY | | | X | X |

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 |
|---|---|
| MM DD YYYY | |

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 |
|---|---|
| MM DD YYYY | |

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 (MM DD YYYY) | LAST DATE OF TREATMENT (MM DD YYYY)

SECOND ATTENDING PHYSICIAN'S NAME

ADDRESS

CITY | STATE | ZIP

PHONE NUMBER | FAX NUMBER | INITIAL DATE OF TREATMENT (MM DD YYYY) | LAST DATE OF TREATMENT (MM DD YYYY)

HOSPITAL NAME

HOSPITAL ADDRESS

CITY | STATE | ZIP

PHONE NUMBER | FAX NUMBER | ADMISSION DATE (MM DD YYYY) | DISCHARGE DATE (MM DD YYYY)

## 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? YES [X] NO [X]

SOCIAL SECURITY ACT? YES [X] NO [X]

STATE DISABILITY BENEFITS? YES [X] NO [X]

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?

FROM (MM DD YYYY) | THROUGH (MM DD YYYY)

**PARTIAL DISABILITY:**
BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?

FROM (MM DD YYYY) | THROUGH (MM DD YYYY)

DATE LAST WORKED (MM DD YYYY)

DATE RETURNED TO WORK (MM DD YYYY)

**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. |
|---|---|---|
| | | |

| CITY | STATE | ZIP |
|---|---|---|
| | | |

| PHONE NUMBER | BIRTH DATE | CLAIM NUMBER (IF AVAILABLE) |
|---|---|---|
| | MM DD YYYY | |

| DATE LAST WORKED | DATE RETURNED TO WORK | | MONTHLY EARNINGS |
|---|---|---|---|
| MM DD YYYY | MM DD YYYY | FULL TIME [X] PART TIME [X] | $ , |

**POLICY NUMBER(S)**

| EMPLOYEE'S OCCUPATION | DESCRIPTION OF OCCUPATION'S PRIMARY DUTIES |
|---|---|
| | |

**WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY?** YES [X] NO [X] **PAID?** YES [X] NO [X]

**IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION CARRIER. ALSO, SEND REPORT OF INITIAL INJURY.**

**NAME**

**ADDRESS**

| CITY | STATE | ZIP |
|---|---|---|
| | | |

**PHONE NUMBER**

**PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)**

**SITTING** HH MM **PER DAY** **WALKING** HH MM **PER DAY** **CLIMBING STAIRS/LADDERS** HH MM **PER DAY** **DRIVING** HH MM **PER DAY**

**LIFTING:** [X] **LESS THAN 15LBS** [X] **15 TO 45LBS** [X] **MORE THAN 45LBS** **STOOPING/BENDING:** [X] **NONE** [X] **SELDOM** [X] **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** | **FROM** | **THROUGH** |
| MM DD YYYY | MM DD YYYY | MM DD YYYY | MM DD YYYY |

**DURING PARTIAL DISABILITY, DID/WILL EMPLOYEE RECEIVE 75% OR MORE OF HIS PRE-DISABILITY INCOME?** YES [X] NO [X] **IF NO, WHAT PERCENTAGE?** _____ %

**DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)**

| EMPLOYER CONTACT NAME | CONTACT'S POSITION | DATE |
|---|---|---|
| | | MM DD YYYY |

| SIGNATURE | PHONE NUMBER | FAX NUMBER |
|---|---|---|
| | | |

## SECTION G — ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S FIRST NAME | LAST NAME | M.I. | AGE

ADDRESS

CITY | STATE | ZIP

NATURE AND ORIGIN OF: [X] SICKNESS [X] INJURY

DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)

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

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 [X] NO [X]

(IF "YES", STATE WHEN AND DESCRIBE.) MM DD YYYY

HOW DID CONDITION ORIGINATE?

DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.

NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)

DATE MM DD YYYY

PROCEDURE

NAME OF FACILITY

OPEN OR CLOSED REDUCTION — OPEN [X] CLOSED [X]

GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.

OFFICE — DATE MM DD YYYY (3 rows)

NATURE OF TREATMENT(S)

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? YES [X] NO [X]

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?
FROM MM DD YYYY THROUGH MM DD YYYY

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?
(ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?
FROM MM DD YYYY THROUGH 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?
YES [X] NO [X] (IF "YES", GIVE RETURN TO WORK DATE.)

RETURN TO WORK DATE MM DD YYYY

IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.
HOSPITAL NAME

ADMISSION DATE MM DD YYYY

DISCHARGE DATE MM DD YYYY

ADDRESS

CITY | STATE | ZIP

PHYSICIAN'S NAME | DEGREE | SIGNATURE

PHONE NUMBER | FAX NUMBER | DATE MM DD YYYY | STAMP

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.

CHUBB

**Chubb Workplace Benefits**
Claim Department • P.O. Box 6803 • Scranton, PA 18505-6803
Telephone 1-866-445-8874 • Fax 1-312-351-7120

## 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.

## FRAUD NOTIFICATIONS CONTINUED

**OHIO:** 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.

**OKLAHOMA:** 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.

**PENNSYLVANIA:** 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.

**PUERTO RICO:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**RHODE ISLAND:** 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.

**TENNESSEE:** 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.

**TEXAS:** 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.

**VIRGINIA:** 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.

**WASHINGTON:** 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.

**WEST VIRGINIA:** 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.

**ALL OTHER STATES:** Any person who knowingly and with intent to defraud any insurance company or other persons, 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, subject to criminal prosecution and/or civil penalties.

**NEW YORK:** 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.

## REQUIRED SIGNATURE OF CLAIMANT

By making claim to these proceeds, I declare that all the answers recorded on this statement are true and complete to the best of my knowledge and belief. I have read the applicable fraud notification statement. I also understand the Company reserves the right to require or obtain further information, should it be deemed necessary.

X_____ _____ _____

CLAIMANT'S SIGNATURE | DATE | PLEASE PRINT NAME

I signed on behalf of the claimant, as _____ (relationship). If you are the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

If your policy/certificate is paid with pre-tax dollars, benefits paid may be reported to the IRS. Contact your employer regarding reporting requirements.

**You must sign and date this claim form on the signature line provided on this page. If you do not sign this claim form, we cannot accept your claim submission.**

CHUBB

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Telephone 1-866-445-8874 • Fax 1-312-351-7120

## 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 _____ Date: _____
(Signature of Claimant) (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.