CHUBB

Disability Claim Form

CHUBB Group of Insurance Company
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
888-293-9229

How to File Your Claim:

(A) Complete all questions CLAIMANT'S STATEMENT, Part I. If additional space is needed, attach separate sheet.
(B) Sign and date completed form.
(C) Have EMPLOYER'S STATEMENT, Part II, completed and signed by your employer (Reverse Side).
(D) Have DOCTOR'S STATEMENT, Part III, completed and signed by your doctor (Reverse Side).
(E) Send form to: Administrative Concepts, Inc., P.O. Box 4000, Collegeville, PA 19426-9000

IN ORDER TO AVOID DELAY, PLEASE ANSWER ALL QUESTIONS COMPLETELY

PART I CLAIMANT'S STATEMENT

Insured's Name First M.I.	Social Security number	Date of birth	Certificate #

Residence
Residence telephone #
Business telephone #

Were you employed when disability began ❑ Yes ❑ No	If yes, give your occupation, employer's name and address
Date of accident	Describe injuries sustained. If accident, state where or how it occurred.

Date you stopped working because of this condition Date you resumed any work?	Period of total disability From: To:	Period of partial disability From: To:	List job duties you are unable to perform while partially disabled or residually disabled.

Medical treatment in the past five years, including current physicians:
Date Doctor, hospital or clinic name Address

List other sources of disability income benefits claimed, including Worker's Compensation and Social Security, (if none, indicate by writing "none".)
Company/organization Address Policy/claim # Benefit amount

Have you filed for Social Security Disability income?
❑ Yes ❑ No If yes, please enclose a copy of the award or denial letter.

Is the condition related to an auto accident? ❑ Yes ❑ No If yes, please provide us with a copy of the accident report.	If yes, provide name and address of the insurance company. Include policy #.

Are you self-employed? If yes, indicate type of business entity: ❑ Sole proprietorship ❑ Partnership ❑ C Corp ❑ S Corp
❑ Yes ❑ No Does your employer/business contribute to payment of your premiums? ❑ Yes ❑ No

I *authorize* any physician, health care practitioner, pharmacy, hospital, other medical facility, insurance company, employer, benefit plan administrator, Veteran's Administration, Internal Revenue Service, consumer reporting agency, financial institutions, the Social Security Administration, any insurance support organization, release all information regarding the non-medical and medical history, diagnosis and prognosis, treatment, (including drug and alcohol abuse information), disability, employment, earnings or benefits under other insurance coverage to CHUBB Group of Insurance Company, EQUIFAX Services or any Consumer Reporting Agency acting on behalf of the Company for the purpose of determining benefits payable in connection with any claim, or any other use as law permits.

I authorize CHUBB Group of Insurance Company or its reinsurers to request dates of past and present claims and names of insurers , excluding medical orpersonal information, from the Health Claims Index operated for subscriber insurers by the Medical Information Bureau (MIB), an association of life insurance companies. I understand the dates of my past and present claims may be reported to MIB.

A copy of this authorization will be sent to me upon request. This photocopy of the original shall be valid for two years from the date of the signature, or for the duration of the claim, whichever is longer.

Any person who knowingly presents a false or fraudulent claim for payment of 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.

Please see attached form.

Signature **Date**

(over)

PART II EMPLOYER'S STATEMENT

This section must be completed if the business actually contributes to the premiums for the insured's Policy(s):

- Employers/Business's contribution to the premiums for this policy(s) is _____%
- Employers/Insured has paid the maximum FICA taxes for the current year ❑ Yes ❑ No
- Employers/Business is exempt from Social Security Taxes ❑ Yes ❑ No
- Employer Tax ID # _____

Authorized Representative Signature | Date

(Do not complete the balance of this Employer's Statement if the insured is self-employed.)

Employer's name | Business telephone # ( )

Street address | City | State | Zip Code

Claimant's occupation?	Weekly Salary	Usual duties?
Full-time work Date ceased? Date resumed?		Part-time work Date ceased? Date resumed?
Name and address of compensation carrier *(if applicable)*		Representative's name/phone

Please list any other disability benefits this employee is eligible for through your company.

Date | Employer's Signature | Official position/title | Phone number ( )

PART III ATTENDING PHYSICIAN'S STATEMENT (Please Answer All Questions)

Diagnosis (Standard Medical Nomenclature) ICE8.CM a/o DSM III.R codes and impairments:

Diagnosis and concurrent conditions
(If diagnosis code other than ICDA used, give name):

Date symptoms first appeared or accident happened:	Date patient first consulted you for this condition:	Has the patient ever had same or similar condition before? ❑ Yes ❑ No If yes, when?
Is present condition the sole cause of disability? ❑ Yes ❑ No	If not, what are other contributing factors?	
If patient has been hospitalized, give date	Name and address of hospital	
Dates of total disability From: To:	Date of partial disability From: To:	Is the patient competent to endorse checks and direct the use of the proceeds thereof? ❑ Yes ❑ No

EXTENT OF DISABILITY	From any occupation	From patient's regular occupation
(a) Is patient now totally disabled?	❑ Yes ❑ No	❑ Yes ❑ No
(b) If no, when was patient able to go to work?	Mo._____Day_____Yr._____	Mo._____Day_____Yr._____
(c) If yes, please estimate when patient will be able to resume working? **Approx. date**	Mo._____Day_____Yr._____ ❑ 1-3 months ❑ 6-12 months ❑ 3-6 months ❑ Never	Mo._____Day_____Yr._____ ❑ 1-3 months ❑ 6-12 months ❑ 3-6 months ❑ Never

Name and address of referring physcian	Name and address of any other practitioner treating this patient
Dates of treatment	

Date | Attending physician (please print) | Signature | Degree | Telephone

Street address | City or town | State (or province) | Zip code

(over)