SUREGO Administrative Services

Accidental Death & Dismemberment

CLAIM FORM & CLAIMANT'S STATEMENT

INSURED INFORMATION (please see ID card for info)

Policy Number		Member ID	
Last Name	Middle Initial	First Name	
Address			
City	State	Zip Code	Country
Email		Phone	

CLAIM INFORMATION

This claim is for: *Check one*

☐ Accidental Death
☐ Accidental Dismemberment

Nature of Dismemberment — Loss of: *Check one*

☐ Right Hand	☐ Right Foot	☐ Sight of Right Eye
☐ Left Hand	☐ Left Foot	☐ Sight of Left Eye
☐ Both Hands	☐ Both Feet	☐ Sight of Both Eyes

Date of Injury		Date of death	
Place where accident happened			
Describe how and where accident occurred			
Name of Beneficiary			
Address of Beneficiary (if different)	City	State	Zip Code

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM DATE OF LOSS.

FOR DEATH BENEFITS – A NOTARIZED COPY OF THE DEATH CERTIFICATE, A COPY OF ANY POLICE REPORT AND A COPY OF THE AUTOPSY INCLUDING TOXICOLOGY RESULTS MUST ACCOMPANY THIS FORM.

FOR DISMEMBERMENT BENEFITS – A COPY OF THE ATTACHED ATTENDING PHYSICIAN STATEMENT MUST BE COMPLETED, SIGNED AND ACCOMPANY THIS FORM.

AUTHORIZATION: I hereby authorize Crum & Forster SPC or its representative, to inspect or secure copies of case history records or any other data necessary to determine eligibility of benefits. I also authorize Crum & Forster SPC or its representative to release and share claim information including that which may be used in the identification and prevention of potential fraudulent activity to any insurance organization, fraud information clearinghouses, designated service providers and business associates assisting in the processing of this claim. A photostatic copy or facsimile of this authorization shall be deemed as effective and valid as the original. This authorization is valid for twelve (12) months from date of signature. I HAVE REVIEWED AND ACKNOWLEDGE THE ATTACHED FRAUD WARNING.

Signature of Insured or Decedent: Date

Signature of Representative: Date

STATEMENT OF ATTENDING PHYSICIAN – FOR DISMEMBERMENT BENEFITS

Patient's Name:	Date of Birth:
1) Nature of injury:	2) Date of injury:

3) Is the claim made for a loss which from illness, disease, bodily infirmity or any bacterial infection occurring from an accidental cut or wound, rather than from the injury sustained? ☐ Yes ☐ No

Loss of Bodily Member

4) If the claim being made due to a loss of member, was the loss due to the injury sustained and not directly or indirectly from any disease or infirmity of mental or bodily nature? ☐ Yes ☐ No

a) Was an amputation performed at or above the wrist or ankle? ☐ Yes ☐ No

b) Date performed ☐ Right Hand ☐ Left Hand ☐ Right Foot ☐ Left foot

Loss of Vision

5) If the claim is being made is for loss of vision, is the loss of sight recoverable by natural, surgical or artificial means? ☐ Yes ☐ No

Loss of Hearing

6) If the claim is being made is for loss of hearing, is the loss of hearing total and permanent in both ears? ☐ Yes ☐ No

a) Is the loss in either ear correctable by any means? ☐ Yes ☐ No

b) If yes, please provide further detail:

Loss of Thumb and Index Finger of Same Hand

7) If the claim is being made is for loss of thumb and finger of same hand, was there a complete Severance* through or above the metacarpophalangeal joints? ☐ Yes ☐ No *(*Severance meaning the complete separation and dismemberment of the part from the body.)*

a) If no, please describe the loss

Physicians Name and AddressNumber & Street	City	State	Zip Code
Physician's Phone Number:	Fax #:	TIN:	
Signature Of Physician:	Date:		

REIMBURSEMENT AUTHORIZATION AND METHOD

I hereby authorize Surego Administrative Services to mail any payments to the below listed address and to deposit any amounts owed me for reimbursement of medical expenses or services rendered by initiating credit entries to my account at the financial institution (hereby BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by Company to my account. In the event that Company erroneously deposits funds in my account (by way of example, I am not entitled to the funds or the amount of deposit Is incorrect or such funds are deposited in the wrong account), I authorize Company to debit or credit my account in the amount necessary to correct the initial deposit, but in no case shall any debit exceed the amount of the initial deposit. I further agree Company is not responsible for any transaction fees charged and will release Surego Administrative Services of any liability in the event of lost or stolen payments. I authorize Surego Administrative Services to contact me using the email address I provided in this form to discuss and/or inform me of payment confirmation.

Account Holder Signature	Date

SELECT ONE FORM OF REIMBURSEMENT

☐ Send a check to address, as listed in CLAIMANT INFORMATION section.		
☐ Send a check to other mailing address:	Street Address	City
	State	Zip Code
☐ Send by Electronic Direct Deposit (fill all fields):	Bank Name	Name on Account
	Account #/IBAN	Routing #/ABA # (for Electronic Direct Deposit)

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW

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.

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.
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.
CALIFORNIA For your protection California law requires the following to appear on this form: 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
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.
FLORIDA WARNING: 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.
KANSAS 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.
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.
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.
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 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.
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.
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.
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 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.
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 payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
VIRGINIA Any person who, with the 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 may have violated state law.

Economic or Trade Sanctions: Any payments under this policy will only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws, and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"). Therefore, any expenses incurred, or claims made involving travel that is in violation of such sanctions, laws and regulations will not be covered under this policy. For more information, You may consult the OFAC internet website at

https : / / www . treasury . gov / about / organizational-structure / offices / Pages / Office-of-Foreign-Assets-Control . aspx.

Electronic Communication: 1. Consent to receive insurance related documents and communications, including but not limited to, your policy documents, disclosures, notices, explanation of benefits (EOB), claims documentation, as well as termination and cancellation or non-renewal notices, electronically to the email address you provide to us through the online application process instead of receiving these records in a paper format from us. 2. Agree and acknowledge that your consent is provided and/or obtained in connection with a transaction affecting interstate commerce subject to the Electronic Signatures in Global and National Commerce Act and the Uniform Electronic Transactions Act, or a similar electronic transactions law, as adopted by state law. 3. Agree that the document(s) delivered to you electronically shall have the same meaning and effect as if you were provided a paper document, whether or not you choose to view the document(s), unless you previously withdrew your consent to receive documents via electronic means as provided below. Electronic document(s) are considered received by you at the time you complete your purchase, unless we receive notice that the email notification was not delivered to you at the email address you provided.

Fraud Warning: If the Covered Person or any person acting on his/her behalf shall make any claim or statement knowing the same to be false or fraudulent as regards to amount or otherwise, then this Insurance shall become void and all claims here under shall be forfeited without refund of premium.

MAILING INSTRUCTIONS

Attention: Surego Administrative Services on Behalf of Crum and Forster SPC
PO Box 2069
Fairhope AL, 36533

Email: claims@mysurego.com