

**CRUM & FORSTER®**

A FAIRFAX COMPANY

A. INSURED / PATIENT / DECEDENT INFORMATION

Name of Policyholder _____		Policy No. _____	
Name of Insured _____		ID# _____	
Home Address _____		_____	
Number & Street	City	State	Zip Code
Name of Deceased / Patient / Relation _____		Date of Birth _____	
Address (if different) _____		_____	
Number & Street	City	State	Zip Code

B. CLAIM INFORMATION

This claim is being made under: (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: _____		

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 MUST ACCOMPANY THIS FORM. ALSO, A COPY OF ANY POLICE REPORT ALONG WITH 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.**NEW YORK FRAUD WARNING:** 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.**AUTHORIZATION:** I hereby authorize Crum & Forster SPC or its representative, to inspect or secure copies of medical records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous conditions, confinements or disabilities. A photo static copy of this authorization and acknowledgment shall be deemed as effective and valid as the original. I ALSO ACKNOWLEDGE THE ATTACHED FRAUD WARNINGS

SIGNATURE OF INSURED _____	DATE _____
OR	
AUTHORIZED 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

i) 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 Address _____
Number & Street City State Zip Code

Physician's Phone Number: _____ Fax # _____ TIN: _____

SIGNATURE OF PHYSICIAN _____ DATE: _____

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 and 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.

MAILING INSTRUCTIONS:

Send this form and any accompanying documentation to:

Attention: Co-ordinated Benefit Plans, LLC On Behalf of Crum and Forster Insurance Company

PO Box 2069

Fairhope AL, 36533