ZURICH

BUSINESS TRAVEL ACCIDENTAL DEATH CLAIM FORM

☐ PERSONAL INSURANCE ☐ GROUP INSURANCE PART I (TO BE COMPLETED BY THE CLAIMANT/BENEFICIARY)

NAME OF DECEASED:	DATE OF BIRTH:	POLICY /CERTIFICATE NO.:
ADDRESS OF DECEASED:	POLICY ISSUED TO:	OCCUPATION OF DECEASED:

DATE OF ACCIDENT: (MONTH) (DAY) (YEAR) HOUR: A.M. P.M.

WHERE DID THE ACCIDENT HAPPEN:

HOW DID THE ACCIDENT HAPPEN:

WHAT WAS THE DECEASED DOING AT THE TIME OF THE ACCIDENT:

WHAT INJURIES WERE RECEIVED:

STATE NAMES AND ADDRESSES OF ALL EYEWITNESSES TO ACCIDENT:

NAME OF HOSPITAL: STAY IN HOSPITAL: FROM: TO:

NAME AND ADDRESS OF DOCTORS ATTENDING THE DECEASED FOLLOWING THE ACCIDENT:

DOCTOR: _____ ADDRESS: _____
DOCTOR: _____ ADDRESS: _____
DOCTOR: _____ ADDRESS: _____
DOCTOR: _____ ADDRESS: _____

WAS THIS ACCIDENT REPORTED TO THE POLICE DEPARTMENT: YES NO IF YES, PLEASE INDICATE POLICE DEPT. NAME:

WAS INQUEST HELD? ☐ YES ☐ NO IF YES, PLEASE ATTACH CERTIFIED COPY OF VERDICT

WAS AUTOPSY HELD? ☐ YES ☐ NO IF SO, WHO CONDUCTED THE AUTOPSY (NAME AND ADDRESS)

WHAT WAS THE DECEASED'S BUSINESS OR OCCUPATION AT THE TIME OF THE ACCIDENT?

EMPLOYER?

DID DECEASED HAVE ANY CHRONIC DISEASE, PHYSICAL DEFECTS OR DEFORMITIES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

LIST OTHER APPLICABLE HEALTH, ACCIDENT, OR LIFE INSURANCE:

COMPANY: _____ POLICY NO.: _____ PRINCIPAL SUM: _____
COMPANY: _____ POLICY NO.: _____ PRINCIPAL SUM: _____
COMPANY: _____ POLICY NO.: _____ PRINCIPAL SUM: _____

WHAT AMOUNT ARE YOU CLAIMING:

DO YOU CLAIM AS:
☐ BENEFICIARY ☐ ADMINISTRATOR ☐ EXECUTOR

DATE OF BIRTH OF BENEFICIARY:

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PERSON TO FURNISH ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL OR MEDICAL RECORDS REGARDING _____ DECEASED.

I HEREBY AUTHORIZE ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE TO RELEASE THE INFORMATION DESCRIBED ABOVE TO ANY EXPERT, INVESTIGATOR, PHYSICIAN, MEDICAL PRACTICIONER, HOSPITAL, MEDICAL OR MEDICAL RELATED FACILITY, INSURANCE COMPANY, REINSURER, PLAN ADMINISTRATOR, PLAN SPONSOR OR EMPLOYER FOR THE PURPOSE OF INVESTIGATING AND/OR ADJUDICATING MY CLAIM. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE:	DATE:
ADDRESS:	
WITNESS:	DATE:
ADDRESS:	

STATEMENT OF ATTENDING PHYSICIAN

In relation to the death of _____, of _____
(name) (address)

1. How long has the Insured been your patient?

2. Please give the names of other physicians who have attended this patient, and the dates of their first and last treatments as reported to you

   Names:_____ Dates of Treatment:_____
   _____
   _____
   _____

3. Date of Death _____Month_____Day_____Year_____Hour_____

4. What was the primary cause of death?_____ natural causes_____, or accident _____

5. Date of accident _____Month_____Day_____Year_____Hour_____

6. On what date did you first attend deceased for the above condition? Month_____ Day_____Year_____

7. Describe his/her condition at that time? _____

8. Between what dates did you treat deceased? From_____To_____

9. How did the accident occur? _____

10. What was the precise nature and extent of injuries? (Describe fully all visible evidence)_____

11. What was the secondary or contributory cause of death?_____

12. Did any disease cause, other than the injury referred to, operate as a complication, or contribute to produce death?_____
    If so, what?_____

13. Was an alcohol and/or drug screen performed? No_____Yes_____

14. Was the Insured confined in a hsopital? No_____Yes_____

    From:_____To_____

_____ _____
Attending Physician Signature Date

_____
Street

_____
City, state, zip code

_____
Telephone Number

ZURICH

PROOF OF DEATH

NAME OF DECEASED:		DATE OF BIRTH:	POLICY NO.:
DATE OF EMPLOYMENT:	DATE POLICYHOLDER LAST WORKED:	DATE OF RETURN TO WORK:	EFFECTIVE DATE OF POLICYHOLDER'S INSURANCE:
CLASS OF INSURANCE COVERAGE: DATE TO WHICH PREMIUM IS PAID:			
SALARY OF EMPLOYEE AT TIME OF DEATH:			
THIS IS TO CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE NAMED POLICYHOLDER OR DEPENDENT IS INSURED UNDER THE TERMS OF THE ABOVE POLICY, AND THAT SUCH INSURANCE WAS IN FORCE ON THE DATE DISABILITY COMMENCED.			
DATED:	EMPLOYEE OR ORGANIZATION:	BY	

(**TO BE COMPLETED BY THE GROUP POLICYHOLDER**)

INSTRUCTIONS FOR COMPLETING PROOFS OF DEATH

PROOF OF DEATH WILL CONSIST OF THE FOLLOWING STATEMENTS:

1. A CLAIMANT'S STATEMENT MUST BE EXECUTED BEFORE A WITNESS BY THE PERSON OR PERSON TO WHOM THE INSURANCE IS PAYABLE. IN CONNECTION WITH SUCH STATEMENT THE FOLLOWING SHOULD BE OBSERVED:

   a) IF THERE IS MORE THAN ONE BENEFICIARY, ALL MAY JOIN IN ONE STATEMENT, OR A SEPARATE BLANK WILL BE FURNISHED FOR EACH IF DESIRED.

   b) IF THE POLICY IS PAYABLE TO THE ESTATE OR TO THE EXECUTORS OR ADMINISTRATORS OF THE INSURED, THE STATEMENT IS TO BE EXECUTED BY THE EXECUTOR OF ADMINISTRATOR, A CERTIFICATE OF WHOSE APPOINTMENT AND QUALIFICATION MUST BE FURNISHED.

   c) IF THE POLICY IS PAYABLE TO A MINOR OR A MENTALLY INCOMPETENT PERSON, THE STATEMENT IS TO BE EXECUTED BY THE LEGALLY APPOINTED GUARDIAN, A CERTIFICATE OF WHOSE APPOINTMENT AND QUALIFICATION MUST BE FURNISHED.

   d) IF THE POLICY HAS BEEN ASSIGNED ABSOLUTELY BOTH IN FORM AND IN FACT, THE STATEMENT IS TO BE COMPLETED BY THE ASSIGNEE. IF COLLATERALLY ASSIGNED, THE STATEMENT SHOULD BE COMPLETED BY BOTH THE DESIGNATED BENEFICIARY AND THE ASSIGNEE, AND A STATEMENT AGREED TO BY BOTH PARTIES SHOULD BE FURNISHED SHOWING THE EXTENT OF THE ASSIGNEE'S INTEREST IN THE POLICY.

   e) IF ANY BENEFICIARY IN THE POLICY, OR THE ASSIGNEE, IS DECEASED, A CERTIFICATE OF DEATH OF SUCH PERSON MUST BE FURNISHED.

2. THIS FORM MUST BE ACCOMPANIED BY A CERTIFIED COPY OF THE CERTIFICATE OF DEATH, CORONER'S REPORT AND APPLICABLE POLICE OR HIGHWAY PATROL REPORTS (IF REPORTS ARE NOT AVAILABLE, WE WILL OBTAIN ON YOUR BEHALF). IF AVAILABLE, ATTACH NEWSPAPER CLIPPINGS.

3. A DULY CERTIFIED COPY OF THE VERDICT MUST BE INCLUDED IF AN INQUEST WAS HELD.

4. A COPY OF THE SUMMARY PLAN DESCRIPTION (SPD) AND ALL APPLICABLE PLAN DOCUMENTS MUST BE SUBMITTED BY THE POLICYHOLDER AT THE TIME OF LOSS.

THE ISSUANCE OF THIS FORM IS NOT AN ADMISSION OF THE EXISTENCE OF ANY INSURANCE OR THE VALIDITY OF ANY CLAIM AND IS WITHOUT PREJUDICE TO THE COMPANY'S LEGAL RIGHTS.