Accidental Injury

(To be used for all claims involving accidental dismemberment; loss of sight, hearing, or use; paralysis; coma; in-hospital benefit; and disability)

HOW TO FILE A CLAIM

1. Complete all items on the attached claim form.

2. Attach the following documents (as applicable):
   - Fully completed Attending Physician Statement (Required for all claims)
   - Copies of all police reports, newspaper articles, etc. describing accident
   - Copies of any additional documents that support your claim
   - Copy of itemized hospital bill (In-Hospital Benefit only)

3. Send the completed and signed claim form and all required documents to:

   994 Old Eagle School Road
   Suite 1005
   Wayne, PA 19087-1802
   Phone: (610) 293-9229
   Fax: (610) 293-9299
   www.visit-aci.com

4. Retain a copy for your records.

YOU WILL BE CONTACTED BY A CLAIM ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

IF YOU HAVE ANY CLAIM RELATED QUESTIONS PLEASE CALL CHUBB AT 1-800-CLAIMS-0 (1-800-252-4670)
Accidental Injury Claim
Claimant’s Statement

INSURED INFORMATION

(Please print – Attach separate sheet if additional space required)

Insured’s Name________________________________ Soc. Sec. No. _____-____-_____ Date of Birth ___/____/____ Marital Status ____

Insured’s Address ______________________________________________________________ Phone No. (H)_________________________

________________________________________________________________________________ Phone No. (W)________________________

Name and address of employer ___________________________________________________________________________________________

Policy Number (Required)__________________________ Insured’s Occupation ________________________________________________

Did the insured have any other insurance? _________ If yes, please list all companies, type of insurance, policy numbers and insurance amounts:______________________________________________________________________________________________________________

___________________________________________________________________________________________________________

CLAIM INFORMATION

Date of accident _____/_______/_______ Time and place accident occurred______________________________________________________

Please describe in detail the circumstances of accident (attach separate sheet if needed): ___________________________________________

_____________________________________________________________________________________________________________________

Was the accident related to the Insured’s occupation? ____________ If so, how? __________________________

Please describe the nature of Insured’s injuries:_____________________________________________________________________________

Please list the names and addresses of all treating physicians and hospitals:______________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

Did police or other authorities investigate the accident? ____ If yes, please provide name, address and telephone number of all investigating officers and agencies:________________________________________________________________________________

CLAIMANT INFORMATION (If different than “Insured Information” above)

Claimant’s Name__________________________________________________________ Age_______ Relationship to Insured___________

Claimant’s Address________________________________________________________________ Phone No. (H) ________________________

_________________________________________________________________________________ Phone No. (W)________________________

In what capacity are you making this claim? ________________________________________________________________________________

AUTHORIZATION

I authorize any insurance company, physician, hospital or other healthcare provider, or any other organization, institution or person that may have records, documents or knowledge regarding the insured to release any information requested regarding this claim and the loss reported. I understand this information will be used by the Chubb Group of Insurance Companies, or its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I agree that this authorization shall be valid for the duration of this claim.

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Claimant or authorized person) ___________________________________________ DATE ___/___/____

MAIL TO: 994 Old Eagle School Road Suite 1005 Wayne, PA 19087-1802 Phone: (610) 293-9229 Fax: (610) 293-9299 www.visit-aci.com

Group Name: Americans for Financial Security (AFS)
Policy Number: 99070834
IMPORTANT NOTICE

**Notice to Alaska Claimants:** 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.

**Notice to Arizona Claimants:** 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.

**Notice to Arkansas Claimants:** 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.

**Notice to California Claimants:** Any person who knowingly presents a false or fraudulent 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 may be subject to fines and confinement in state prison.

**Notice to Colorado Claimants:** It is unlawful to knowingly provide false, incomplete, or misleading 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.

**Notice to Delaware Claimants:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

**Notice to District of Columbia Claimants:** 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.

**Notice to Florida Claimants:** 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 the felony of the third degree.

**Notice to Idaho Claimants:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information commits a felony.

**Notice to Indiana Claimants:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Notice to Kentucky Claimants:** 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.

**Notice to Maine Claimants:** 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.

**Notice to Maryland Claimants:** Any person who presents false information in an application for insurance is guilty of 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.

**Notice to Massachusetts Claimants:** Any person who presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to Minnesota Claimants:** A person who submits an application or files a claim with intent to defraud or helps commits a fraud against an insurer is guilty of a crime.

**Notice to New Hampshire Claimants:** 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.

**Notice to New Jersey Claimants:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Notice to New Mexico Claimants:** 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.

**Notice to New York Claimants:** 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.

**Notice to Ohio Claimants:** 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 is guilty of insurance fraud.

**Notice to Oklahoma Claimants:** 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.

**Notice to Oregon Claimants:** Any person who, knowingly and with intent to defraud an insurance company or other person, submits an application or files a claim for insurance that contains any materially false information relating to an insurance company’s acceptance of risk, or conceals for the purpose of misleading, information concerning any fact material to an insurance company’s acceptance of risk, may be guilty of a fraudulent act, which is a crime.

**Notice to Pennsylvania Claimants:** 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.

**Notice to Virginia Claimants:** 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.

**Notice to Claimants in all other states:** Any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.