

BUSINESS TRAVEL ACCIDENT CLAIM FORM

To expedite claim processing, the attached claim forms need to be fully completed and the following instructions must be adhered to. Each claim will be evaluated based on the terms and conditions of the insurance policy. HCC Medical Insurance Services / U.S. Specialty Insurance Company reserves the right to request additional information and/or documents to help us make this evaluation. The acceptance of these forms by the HCC Medical Insurance Services / U.S. Specialty Insurance Company is not an admission of coverage under an insurance policy.

PART I – EMPLOYER’S STATEMENT

Form must be completed in its entirety and certified by an official representative of the employer or the plan.

Please provide the employee’s itinerary or any other information that demonstrates that the employee was on the business of the policyholder at the time of the accident.

Please provide proof of salary (attach W2 or commissions, if applicable)

Please provide the beneficiary designation forms on file with the policyholder, if any. If none on file, the official representative shall certify to that fact on the claim form.

PART II – CLAIMANT’S STATEMENT

To be completed by claimant or beneficiary in its entirety

Please furnish any newspaper accounts or other pertinent information regarding the claim.

PART III – ATTENDING PHYSICIAN’S STATEMENT (REQUIRED FOR ACCIDENTAL DISMEMBERMENT CLAIMS)

Attending physician must complete this form. Any expense for completion of the form will be paid for by the claimant.

MISCELLANEOUS – ALL CLAIMS

Required documents other than claim form

- ✓ Certified true copy of death certificate (Accidental Death Claim)
- ✓ Police Report (if applicable)
- ✓ Autopsy/Post Mortem & Toxicology report (if applicable)
- ✓ All relevant medical reports

If the claim proceeds are payable to an estate, Part II must be completed by the executor or administrator of the estate. A copy of the court document appointing the executor or administrator must be attached to this form.

If any designated beneficiary is a minor, Part II must be completed by the custodian or guardian. A copy of the court document appointing the guardian or a similar document must be attached to this form.

For a foreign death, the official death certificate and the Report of the Death of an American Citizen Abroad form must be attached to the claim form.

FORM SUBMISSION OPTIONS

Paper Form - Mail to:
Tokio Marine HCC - MIS Group
Box No. 2005
Farmington Hills, MI 48333-2005

Email & Fax:
service@hccmis.com
Fax: 317-262-2140

QUESTIONS OR GUIDANCE

For questions or guidance in filling out this form call **1-800-605-2282**

IPART I: EMPLOYER STATEMENT

Policy Number:		Policyholder Name:		Policyholder Phone Number:	
Policyholder Address: (Street, City, State & Zip Code)					
Name of Insured, Employee, Participant:					
Claimant Social Security Number:		Claimant Date of Birth:		Claimant Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Claimant Phone Number:
Claimant Address: (Street, City, State & Zip Code)					
Date of Accident:		Time of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM	Place of Accident:		
Cause of Accident (Attach additional pages if necessary):				Indicate injured body part(s):	
Nature of Sickness (if applicable):				Date Sickness first commenced:	
Claimant's Injury was due to: <input type="checkbox"/> Business related accident, (24 Hour Business Trip Coverage) <input type="checkbox"/> Pleasure related accident, (24 Hour Business and Pleasure Coverage) If Business related accident, list reason for business trip and provide trip verification (i.e. Itinerary, Plane Ticket...):					
Eligible Person "Class Number" (as defined by the Policy) <input type="checkbox"/> Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 <input type="checkbox"/> Other (Explain):					
At the time of the accident, what was the Claimant's employment status? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Explain):					
Claim is filed for: <input type="checkbox"/> Accident Medical Expense (AME) benefits If yes, please submit itemized medical bills (If the policy is Excess, please include any other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted). <input type="checkbox"/> Accident Total Disability (ATD) benefits If yes, please provide the following Claimant information:					
Date last worked:		Salary at time of accident:		Current Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Explain):	
Letter outlining Claimant's "duties of his or her regular occupation"					
<input type="checkbox"/> Accident Death & Dismemberment (ADD) benefits					
Policyholder Certification Signature Required: I hereby certify this information to be true / accurate, the above claimant is a member of a group insured under the above policy number and the Claimant's injury was sustained as a direct result of the accident described above. I further certify I have read and signed the Fraud Warning statement listed on the reverse side of this form.					
_____			_____		
Title of Policy Holder Official			Signature of Policy Holder Official		

			Date (MM/DD/YY)		

PART II: CLAIMANT STATEMENT

INSTRUCTIONS: Complete this form if you are applying for death or dismemberment benefits due to an Accident. If a question does not apply, please mark "N/A".			
GROUP POLICYHOLDER/EMPLOYER NAME:			
Name of Insured Employee/Participant		Social Security Number	
Name of Deceased or Injured (if different from above)		Has a Workers Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", what is the status of the claim?	
Relationship to Employee: <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child	Date of Birth:		
On what date did the accident happen?		Did accident result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No - If "Yes", on what date?	
Where did the accident happen?			
City:	State:	Please describe all injuries received.	
Describe in detail how the accident occurred. (Attach additional pages if necessary)			
Name and address of law enforcement agency involved (Please submit copy of Police Accident Report).			
List name/address/phone # of all physicians consulted for this injury/death.			
List name/address/phone # of all hospitals consulted.			
Did the deceased/injured have any chronic disease or physical defect or deformity? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", describe in detail:			
Was autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", provide name/address/telephone number of coroner, if known		Was an inquest held? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", verdict?	
Name of Beneficiary:	Address:	Telephone Number:	Social Security Number:
Your date of birth:	In what capacity are you making claim?		
Your address:			
Telephone number:		Your relationship to deceased or injured:	Your Social Security Number:
<p>I verify that all information contained in this form is true, correct and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health-related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the insured named below, to provide this information to Tokio Marine HCC - Medical Insurance Services Group. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed. I further certify I have read and signed the Fraud Warning statement listed on page 5 of this form:</p>			
_____ Claimant Signature			
_____		_____	
Print Name		Date (MM/DD/YY)	

PART III: ATTENDING PHYSICIAN STATEMENT
ATTENDING PHYSICIAN MUST COMPLETE THIS FORM. Any expense for completion of the form will be paid by claimant.

Name of Patient:		Date of Birth:		Address (Street, City, State, Zip Code):	
When did accident happen? (Month, Day, Year)			When did patient first consult you for this condition? (Month, Day, Year)		
Nature of injury: Please explain in complete detail, including all diagnoses, any dismemberment or loss of use; the cause or incident causing the injury, and all affected body parts.					
If injury resulted in severance of a body part, please indicate the precise location of the severance:					
Did injury result in the total and irrecoverable loss of hearing in both ears? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of loss:					
Did the injury result in: <input type="checkbox"/> Paralysis <input type="checkbox"/> Quadriplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Hemiplegia					
In your opinion, was any disease, infection, bodily or mental infirmity an underlying cause in the loss(es) indicated above?					
If an operation is contemplated, give approximate date and nature of the operation:					
In your opinion, did the loss(es) result from any self-inflicted injury or attempted self-destruction? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If injury resulted in loss of sight, was the loss total and irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No Which eye was injured? <input type="checkbox"/> Right <input type="checkbox"/> Left Was the eye removed? <input type="checkbox"/> Yes <input type="checkbox"/> No On what date did the total and irrecoverable loss occur? If the loss of sight is partial, but irrecoverable, please state amount of vision in each eye with Snellen notations, or Jaeger scale, if pertinent.					
Uncorrected		Corrected		Date of Examination:	
O.D.	O.S.	O.D.	O.S.		
Do you believe vision can be restored in whole or in part by treatment or operation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Was patient confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give name and address of hospital and dates of confinement:					
TREATMENT					
Date of first visit	Dates of Subsequent Visits:				
Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If discharged, give date of discharge:					
Signature of Attending Physician		Physician's Name (Please Print)		Degree	Telephone
Street Address:			City or Town		State or Province
					Zip Code

FRAUD STATEMENTS

Important Notice

Applicable in Alabama, Arkansas, District of Columbia, Louisiana, New Mexico, Rhode Island, and West

Virginia: 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.

Applicable in 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.

Applicable in California: For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

Applicable in 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.

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

Applicable in Florida: 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.

Applicable in Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in Kentucky, 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.

Applicable in Maine: 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 and denial of insurance benefits.

Applicable in Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Applicable in Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in 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.

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

Applicable in 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 subjects such person to criminal and civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in 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.

Applicable in Oklahoma: 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.

Applicable in Oregon: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in Tennessee, Virginia, and Washington: 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.

Applicable in Texas: 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.

Applicable in Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

In General, and for all other states not previously stated: 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.