Medical Insurance Services Group
U.S. Specialty Insurance Company (USSIC)
Box No. 2005
Farmington Hills, MI 48333-2005
1-800-605-2282 / 317-262-2132

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**

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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:** ☐ **Male** ☐ **Female**	**Claimant Phone Number:**
Claimant Address: (Street, City, State & Zip Code)			
Date of Accident:	**Time of Accident:** ☐ **AM** ☐**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:

☐ **Business related accident, (24 Hour Business Trip Coverage)** ☐**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) ☐**Class 1** ☐**Class 2** ☐**Class 3** ☐**Other (Explain):**

At the time of the accident, what was the Claimant's employment status? ☐ **Full-time** ☐**Part-time** ☐**Other (Explain):**

Claim is filed for:

☐ **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).

☐ **Accident Total Disability (ATD) benefits**
If yes, please provide the following Claimant information:

Date last worked:	**Salary at time of accident:**	**Current Employment Status:** ☐ **Full-time** ☐**Part-time**	☐**Other (Explain):**
Letter outlining Claimant's "duties of his or her regular occupation"			

☐ **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)

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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? ☐ Yes ☐ No If "Yes", what is the status of the claim?**
Relationship to Employee: ☐**Spouse/Domestic Partner** ☐**Child** / **Date of Birth:**	
On what date did the accident happen?	**Did accident result in death?** ☐**Yes** ☐ **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? ☐Yes ☐ No
If "Yes", describe in detail:

Was autopsy performed? ☐Yes ☐ No **If "Yes", provide name/address/telephone number of coroner, if known**	**Was an inquest held? ☐Yes ☐ 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:**

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:

_____
Claimant Signature

_____ _____
Print Name **Date (MM/DD/YY)**

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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? ☐Yes ☐ No Date of loss:

Did the injury result in:
☐Paralysis ☐ Quadriplegia ☐ Paraplegia ☐ 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? ☐Yes ☐ No

If injury resulted in loss of sight, was the loss total and irrecoverable? ☐Yes ☐ No Which eye was injured? ☐ Right ☐ Left
Was the eye removed? ☐Yes ☐ 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? ☐Yes ☐ No

Was patient confined to a hospital? ☐ Yes ☐ 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? ☐Yes ☐ No

If discharged, give date of discharge:

Signature of Attending Physician	Physician's Name (Please Print)	Degree	Telephone	Date

Street Address:	City or Town	State or Province	Zip Code

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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 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 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, Ohio, 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

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 New Jersey: Any person who includes any false or misleading information on an application for an insurance policy 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 Oklahoma: 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.

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.