

Claims Made Easy



Your claim is processed ten days faster* when you submit a claim online at www.chubb.com/us-en/claims/chubb-workplace-benefits.aspx

FILING A CLAIM BY MAIL

1. Download the claim form.
2. Print all pages of the claim form.
3. Complete all sections of the Claimant Statement.
4. Sign and date at the bottom of the second page. You must sign and date this claim form on the signature line provided on this page. *If you do not sign this claim form, we cannot accept your claim submission.*
5. If you are claiming disability, have your employer complete and sign the **Employer's Statement** found in **SECTION C** on the third page.
6. Have your physician complete **SECTION D**, the **Attending Physician's Statement**, on the fourth page.
7. Sign and date the Authorization to Obtain and Disclose Health Information.
8. Send your signed, completed claim form with the Attending Physician's Statement, Employer Statement, if applicable, and any medical bills or documentation that you may have related to your accident or illness to:

Chubb Workplace Benefits

Claim Department
PO Box 6803
Scranton, PA 18505-6803

* On average

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HELPFUL TIPS:

First page (Claimant completes)

Please include your complete name and current mailing address on the claim form as any payment and/or correspondence will be sent to the address indicated on the claim form. Indicate your policy numbers/certificate numbers on the claim form; this will help us respond quicker.



Accident: For loss due to an accidental bodily injury, please complete the Accident section of the form including a detailed description of how the accident occurred.



Sickness: If filing for loss due to sickness, fill in the section of the form relating to symptoms and diagnosis. You may be requested to provide additional details regarding medical treatment you received within the 5 years prior to your policy effective date.



Critical Illness: If filing a critical illness claim, please fill in the date of diagnosis and provide a copy of the pathology report or test results confirming the diagnosis and the level of severity.



Hospitalization: If hospitalized, provide us with the name and address of the hospital including the admission and discharge dates. Please also send a copy of the itemized hospital bill including the number of days you were an inpatient.



Disability: If you were disabled and have disability coverage, give the exact dates of the total and/or partial disability. If you are still disabled at the time you submit your claim form, another claim form will be sent to you for continuing disability.



Wellness: If filing for wellness/preventative/health screening benefits, please review your policy carefully to ensure the test or procedure is covered under your policy. Do not use the attached claim form if filing for wellness or health screening benefits. Rather use the Health and Wellness claim form which can be found at www.chubb.com/us-en/claims/chubb-workplace-benefits.aspx.

Additional: Please be sure to sign and date the **Authorization to Release Information**. This will prevent unnecessary delays in the event additional information is needed.

Third page (Employer completes)

If you are employed outside the home, your employer must verify your disability by completing **Section C – Employer's Statement**. Please note: If the insured is a student, the school principal should complete this section.

Fourth page (Doctor completes)

Your primary physician must complete **Section D – Attending Physician's Statement** in its entirety. Failure to make sure that your physician fills in all necessary information on the claim form may cause delays in the processing of your claim.

For your records, we suggest that you keep a copy of the completed claim form and any bills you submit. Note the date mailed. Mail all pages of the completed form and any enclosures to:

Chubb Workplace Benefits

Claim Department
PO Box 6803
Scranton, PA 18505-6803



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* On average

IMPORTANT INSTRUCTIONS FOR FILING CLAIM

1. USE THIS CLAIM FORM FOR ALL CLAIMS EXCEPT FOR WELLNESS/PREVENTATIVE/HEALTH SCREENING BENEFITS.
2. IF DISABILITY IS CLAIMED, PLEASE HAVE YOUR EMPLOYER OR SCHOOL COMPLETE SECTION C, THE EMPLOYER'S STATEMENT.
3. IF MEDICAL OR HOSPITAL BENEFITS ARE CLAIMED, ITEMIZED BILLS MUST BE ATTACHED.

SECTION A CLAIMANT STATEMENT									
PLEASE PRINT									
FIRST NAME					LAST NAME			M.I.	
E-MAIL ADDRESS (Your e-mail address will be updated with this information if different from the e-mail on file)									
PLEASE LIST OTHER NAMES THAT YOU MAY USE SUCH AS MAIDEN NAME, NICKNAME, ETC.					PRIMARY PHONE		SECONDARY PHONE		
MAILING ADDRESS									
CITY							STATE	ZIP	
SOCIAL SECURITY # (LAST 4 DIGITS)		BIRTH DATE		HEIGHT (FT/IN)		WEIGHT (LBS)		MALE	FEMALE
								☒	☒
POLICY/CERTIFICATE NUMBER(S)									
EMPLOYER'S NAME									
EMPLOYER'S ADDRESS									
CITY							STATE	ZIP	
EMPLOYER'S CONTACT NAME					EMPLOYER'S CONTACT PHONE NUMBER		EMPLOYER'S CONTACT FAX NUMBER		
YOUR OCCUPATION								MONTHLY EARNINGS	
BRIEFLY DESCRIBE YOUR OCCUPATIONAL DUTIES									
HAVE YOU FILED A CLAIM UNDER THE FOLLOWING:									
WORKERS' COMPENSATION ACT?		SOCIAL SECURITY ACT?		STATE DISABILITY BENEFITS?		IF YES TO ANY OF THE PRECEDING, PLEASE SUBMIT A COPY OF THE AWARD OR DENIAL LETTER IF RECEIVED.			
YES ☒ NO ☒		YES ☒ NO ☒		YES ☒ NO ☒					
IF YOU HAVE OTHER ACCIDENT-SICKNESS DISABILITY INSURANCE, GIVE COMPANY NAME, ADDRESS, AND BENEFIT AMOUNT. (IF NONE, STATE "NONE")									
COMPANY NAME									
ADDRESS									
CITY							STATE	ZIP	
BENEFIT AMOUNT									
WEEKLY		\$		BI-WEEKLY		\$		MONTHLY	

SECTION B CLAIMANT STATEMENT	
PLEASE COMPLETE ALL APPLICABLE SECTIONS BELOW AND SUBMIT DOCUMENTATION TO SUBSTANTIATE COVERED SERVICES CLAIMED UNDER YOUR POLICY.	
COMPLETE FOR ACCIDENT CLAIM	
DATE OF ACCIDENT	INJURIES SUSTAINED
PLEASE PROVIDE AN EXACT DESCRIPTION OF WHERE YOU WERE WHEN ACCIDENT OCCURRED INCLUDING A DETAILED DESCRIPTION OF WHAT HAPPENED TO YOU.	

COMPLETE FOR SICKNESS CLAIM

IF FILING FOR CRITICAL ILLNESS BENEFITS, PLEASE ATTACH A COPY OF THE PATHOLOGY REPORT OR TEST(S) THAT CONFIRM THE DIAGNOSIS AND THE SEVERITY OF THE CONDITION.

DATE OF DIAGNOSIS FOR CURRENT SICKNESS

SICKNESS DIAGNOSIS IF KNOWN

MM DD YYYY

PLEASE PROVIDE ADDITIONAL DETAILS INCLUDING SYMPTOMS.

COMPLETE FOR EITHER ACCIDENT OR SICKNESS CLAIM

FIRST ATTENDING PHYSICIAN'S NAME

ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER

INITIAL DATE OF TREATMENT

MM DD YYYY

LAST DATE OF TREATMENT

MM DD YYYY

SECOND ATTENDING PHYSICIAN'S NAME

ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER

INITIAL DATE OF TREATMENT

MM DD YYYY

LAST DATE OF TREATMENT

MM DD YYYY

HOSPITAL NAME

HOSPITAL ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER

ADMISSION DATE

MM DD YYYY

DISCHARGE DATE

MM DD YYYY

COMPLETE FOR DISABILITY CLAIM**TOTAL DISABILITY:**

BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES?

FROM

MM DD YYYY

THROUGH

MM DD YYYY

PARTIAL DISABILITY:

BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?

FROM

MM DD YYYY

THROUGH

MM DD YYYY

DATE LAST WORKED

MM DD YYYY

DATE RETURNED TO WORK

MM DD YYYY

PLEASE HAVE YOUR EMPLOYER COMPLETE AND SIGN SECTION C - EMPLOYER'S STATEMENT FOUND ON THE NEXT PAGE. IF THE INSURED IS A STUDENT, THE SCHOOL PRINCIPAL SHOULD COMPLETE THIS SECTION.

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.

X

CLAIMANT'S SIGNATURE

DATE

PLEASE PRINT NAME

I signed on behalf of the claimant, as (relationship). If you are the Power of Attorney, Guardian or Conservator, please attach a copy of the document granting authority.

If your policy/certificate is paid with pre-tax dollars, benefits paid may be reported to the IRS. Contact your employer regarding reporting requirements.

You must sign and date this claim form on the signature line provided on this page.

If you do not sign this claim form, we cannot accept your claim submission.

SECTION C										EMPLOYER'S STATEMENT											
IF YOU ARE EMPLOYED OUTSIDE THE HOME, YOUR EMPLOYER MUST VERIFY YOUR DISABILITY BY COMPLETING SECTION C – EMPLOYER'S STATEMENT. PLEASE NOTE: IF THE INSURED IS A STUDENT, THE SCHOOL PRINCIPAL SHOULD COMPLETE THIS SECTION.																					
EMPLOYEE'S FIRST NAME										LAST NAME										M.I.	
CITY										STATE					ZIP						
PHONE NUMBER					BIRTH DATE					CLAIM NUMBER (IF AVAILABLE)											
DATE LAST WORKED					DATE RETURNED TO WORK					FULL TIME ☒ PART TIME ☒					MONTHLY EARNINGS						
POLICY NUMBER(S)																					
EMPLOYEE'S OCCUPATION										DESCRIPTION OF OCCUPATION'S PRIMARY DUTIES											
WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY? YES ☒ NO ☒ PAID? YES ☒ NO ☒																					
IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF COMPENSATION CARRIER. ALSO, SEND REPORT OF INITIAL INJURY.																					
NAME																					
ADDRESS																					
CITY										STATE					ZIP						
PHONE NUMBER																					
PHYSICAL JOB DEMANDS (HH = hours, MM = minutes)																					
SITTING ☒ HH ☒ MM PER DAY WALKING ☒ HH ☒ MM PER DAY CLIMBING STAIRS/LADDERS ☒ HH ☒ MM PER DAY DRIVING ☒ HH ☒ MM PER DAY																					
LIFTING: ☒ LESS THAN 15LBS ☒ 15 TO 45LBS ☒ MORE THAN 45LBS STOOPING/BENDING: ☒ NONE ☒ SELDOM ☒ FREQUENT																					
TOTAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE NOT PERFORM ANY JOB DUTIES?										PARTIAL DISABILITY: BETWEEN WHAT DATES DID THE EMPLOYEE ONLY PERFORM PARTIAL JOB DUTIES?											
FROM					THROUGH					FROM					THROUGH						
DURING PARTIAL DISABILITY, DID/WILL EMPLOYEE RECEIVE 75% OR MORE OF HIS PRE-DISABILITY INCOME? YES ☒ NO ☒ IF NO, WHAT PERCENTAGE? %																					
DESCRIPTION OF DUTIES PERFORMED (IF ON PARTIAL DISABILITY)																					
EMPLOYER CONTACT NAME										CONTACT'S POSITION										DATE	
SIGNATURE										PHONE NUMBER					FAX NUMBER						

SECTION D		ATTENDING PHYSICIAN'S STATEMENT			
PATIENT'S FIRST NAME		LAST NAME		M.I.	AGE
ADDRESS					
CITY		STATE	ZIP		
NATURE AND ORIGIN OF:		DIAGNOSIS (DESCRIBE COMPLICATIONS, IF ANY)			
☒ SICKNESS					
☒ INJURY					
WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?		WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?		IF SICKNESS, WHEN WAS CONDITION FIRST DIAGNOSED?	
INDICATE THE DATE AND TYPE OF DIAGNOSTIC TEST USED TO DIAGNOSE CURRENT CONDITION. IF MORE TESTS WERE PERFORMED, PLEASE INCLUDE SUPPORTING DOCUMENTATION.					
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?		(IF "YES", STATE WHEN AND DESCRIBE.)			
YES ☒ NO ☒					
HOW DID CONDITION ORIGINATE?		DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION.			
NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE(S), IF ANY. (DESCRIBE FULLY)					
DATE	PROCEDURE			OPEN OR CLOSED REDUCTION	
				OPEN ☒ CLOSED ☒	
	NAME OF FACILITY				
GIVE DATES OF TREATMENT AND NATURE OF TREATMENT OTHER THAN SURGICAL.					
OFFICE	DATE	NATURE OF TREATMENT(S)			
		NAME OF FACILITY			
EMERGENCY ROOM (ER)	DATE	NATURE OF TREATMENT			
		NAME OF FACILITY			
URGENT CARE FACILITY	DATE	NATURE OF TREATMENT			
		NAME OF FACILITY			
IS THE PATIENT STILL UNDER YOUR CARE?	HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)?		HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? (ONLY ABLE TO WORK PART TIME OR PERFORM PARTIAL JOB DUTIES)?		
YES ☒ NO ☒	FROM	THROUGH	FROM	THROUGH	
PLEASE STATE RESTRICTIONS PLACED ON PATIENT FOR ANY DISABILITY THAT HAS BEEN INDICATED.					
IF PATIENT DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE?			RETURN TO WORK DATE		
YES ☒ NO ☒ (IF "YES", GIVE RETURN TO WORK DATE.)					
IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT.			ADMISSION DATE		DISCHARGE DATE
HOSPITAL NAME					
ADDRESS					
CITY		STATE	ZIP		
PHYSICIAN'S NAME		DEGREE	SIGNATURE		
PHONE NUMBER	FAX NUMBER		DATE	STAMP	
ADDRESS					
CITY		STATE	ZIP		
MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE					
INDIVIDUAL PRACTITIONER'S S.S. NO.			ALL OTHERS - EMPLOYER I.D. NO.		

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Claim or Policy Number:			
Name:		Doctor's Name:	
Address:			
Birthdate:	/ /	Adm.	/ /
		Disch.	/ /
		Hospital's Name:	

This will authorize COMBINED LIFE INSURANCE COMPANY OF NEW YORK, to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from any Prescription Drug Database, all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated. I further authorize Combined to rely on this authorization for two years, or as otherwise permitted by law, to disclose information about me for purposes of processing my insurance claims, including assistance with return to work.

The information to be disclosed may include but is not limited to:

- | | | |
|----------------------------|----------------------|---------------------|
| History of Present Illness | Consultant's Report | Discharge Summary |
| Operative Reports | Pathology Reports | Laboratory Results |
| Daily Doctor's Notes | Past Medical History | Previous Admissions |
| X-Ray Reports | Blood/Toxicology | |

The information is needed for the following purpose(s): Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand upon fulfillment of the above stated purposes, this consent will expire (24) months following date of signature without any express revocation. I understand and I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to Combined Life Insurance Company of New York. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy/certificate or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

X (Signature of Claimant)	Date: (Must be filled in)
X (Signature of Parent or Guardian)	 (Relationship to Patient if Signed by Guardian)

A photocopy of this authorization may be treated in the same manner as an original.