Accidental Death

HOW TO FILE A CLAIM

1. **Complete all items on the attached claim form.**

2. **Attach the following documents (as applicable):**

   - **Certified copy of death certificate (Required for all claims)**
   - **Certified copy of all documents supporting claimant's authority (e.g., Letters Testamentary, Letters of Administration, Guardianship Papers, etc.,)**
   - **Copies of all police reports, newspaper articles, etc. describing accident**

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

Crawford Adjusters Canada
180 King Street, 4th Floor
Waterloo, Ontario N2J 1P0
Attention: New Claims

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 Crawford Adjusters Canada at +1 (877) 597-8990

Accidental Death

Claimant's Statement

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

INSURED INFORMATION

Insured's Name ______________________________ Soc. Ins. No. _____-_____-_____ Date of Birth ____/____/____ Marital Status _____

Insured's Address ____

Policy Number (Required)__________________________ Insured's Occupation (at time of death) ________________________

Name and address of last employer ____

Did the insured have any other accident or life insurance? ___________ If yes, please list all companies, 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 accident related to the Insured's occupation or fire fighting duties? _______ If Yes, how? ______________________________

Please describe the cause of the Insured's death: ____

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: ____

Was an autopsy performed?________ If yes, please provide name and address of Medical Examiner: _________________________

____

Was a coroner's inquest held? ______ If yes, what was the determination?____

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

Claimant was a member of your organization at the time of the injury or illness? ☐ Yes ☐ No

Were they engaged in an authorized fire department activity at time of injury or illness? ☐ Yes ☐ No

Policy #:_______________

Fire/Rescue/Ambulance Company/District Name: ____

Fire/Rescue/Ambulance Company/District Address: ____

____ Phone No. (W)______________________________

Print Name and Title ___________________________________ Signed _______________________________ Date _______________

CLAIMANT INFORMATION

Claimant's Name____ Age_______ Relationship to Insured ____________________

Claimant's Address____ Phone No. (H)______________________________

____ Phone No. (W)______________________________

In what capacity are you making this claim? _____ Beneficiary ______ Executor* ______ Administrator* _____ Guardian* _____Trustee* _____Assignee*

*Please provide certified copy all documents supporting your authority (e.g., Letters Testamentary, Letters of Administration, etc.)

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, and its authorized representatives, for the purpose of evaluating and determining coverage for this claim. I also authorize Chubb to release information regarding the status, progress, or outcome of this claim to the Producer or Broker/Agent for this policy. 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 _____/_____/_____