STARR
INSURANCE COMPANIES

ACI

Accidental Death Claim Filing Instructions

PROOF OF ACCIDENTAL DEATH SHALL CONSIST OF THE FOLLOWING:

1. A completed and signed claim form
2. Proof of Coverage
3. Certified Death Certificate
4. Obituary notice and any newspaper clipping you may have
5. Official Accident, Incident, Toxicology or Medical Examiners Reports
   - Police report, emergency medical services report, coroners report, autopsy report
6. Attending Physician's Statement
7. Authorization to obtain medical records
8. If death occurs outside of the United States a certified copy of the Office Record of Death must be furnished

Return completed claim form and all other supporting documentation to:

Administrative Concepts, Inc.
ATTN: Claims Department
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
Email: ACI247@acitpa.com
Fax: 610-293-9299
Phone: 1-888-293-9229

A PROPERLY COMPLETED CLAIM FORM WILL ASSIST US IN THE PROMPT PROCESSING OF YOUR CLAIM

Note: If you need additional space in order to complete the Claim Form, please attach a separate sheet of paper with your responses.

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STARR
INSURANCE COMPANIES

Accidental Death Claim Form

Proof of Claim- Accidental Death

(No Liability is admitted by the issue of this form)

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

MAIL TO:
Administrative Concepts, Inc.
994 Old Eagle School Road
Suite 1005
Wayne, PA 19087-1802
Fax - (610) 293-9299
Email: ACI247@acitpa.com

Statement of Beneficiary

Insured	Certificate number(s)

Facts concerning deceased

Full Name:			
Last Name	First Name	M.I.	Social Security #

Home Address:

# and Street	City/Town	State	Zip Code

Date of Birth:	Place of Birth:	Social Security Number:
Occupation:	Name of Employer:	

Employer's Address:

Beneficiary

Name of Beneficiary:		
Last Name First Name M.I.	Social Security #	Date of Birth:

Address:

# and Street	City/Town	State	Zip Code

Relationship to Insured:	Telephone number:

Complete for all claims

Date of Accident:	Place accident occurred:

Describe how accident occurred:

Did the accident happen at work: Yes ☐ No ☐ Has a claim or will a claim be filed under worker's compensation? Yes ☐ No ☐

Name of worker's compensation carrier:

Address:

# and Street	City/Town	State	Zip Code

To be completed if Death resulted from motor vehicle accident

Type of Vehicle:	Registered Owner	Was deceased the driver? Yes ☐ No ☐

Use of vehicle: ☐ Business ☐ Pleasure ☐ Business and Pleasure

Name of law enforcement agency investigating accident:

Address:

# and Street	City/Town	State	Zip Code

To be completed on all claims

Was an inquest held: Yes ☐ No ☐ If "yes", complete the following and attach a copy of the proceedings and verdict

Name of court holding hearing:

# and Street	City/Town	State	Zip Code

Was an autopsy conducted Yes ☐ No ☐ If "yes", complete the following and attach a copy of the report

Name of person conducting autopsy:	Title:

Address:

# and Street	City/Town	State	Zip Code

First physician attending deceased after injury

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	

Other physicians attending deceased after injury

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	

Previous medical history

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Medical Condition:	Dates of Treatment:
Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Medical Condition:	Dates of Treatment:

Other Insurance on life of deceased

Company name:	Amount:
Address:	
# and Street / City/Town / State / Zip Code	
Company name:	Amount:
Address:	
# and Street / City/Town / State / Zip Code	

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, Insurance support organization, governmental agency, group policyholder, Insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of beneficiary/ claimant	Dated
Address:	

IMPORTANT NOTICE

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: 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.

Arizona, Arkansas and Rhode Island: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR and RI:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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.

Florida: and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime, **specific to PA**: subjects such person to criminal and civil penalties and specific to NY: 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.

Louisiana, New Mexico, Texas and West Virginia: presents a false or fraudulent claim for the payment of a loss (or **specific to LA, TX and W VA**: who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM**: to civil fines and criminal penalties.)

Maryland: and willfully presents a false or fraudulent claim for payment of loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: 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.

Oklahoma: 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.

Oregon: and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto, may be subject to prosecution for insurance fraud.

Puerto Rico: and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

WARNING:

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.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine/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 may include imprisonment, fines or a denial of insurance benefits.

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

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.

Tennessee and Virginia : It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company. Penalties include imprisonment, fines and denial of insurance benefits.