Zurich Claim Forms:

Pages 2-5 - Accident Medical Expense Claim Form

Pages 6-8 – Accident Dismemberment Claim Form

Pages 9-10 – Accidental Death Claim Form

ZURICH AMERICAN INSURANCE COMPANY

PROOF OF CLAIM – ACCIDENT MEDICAL EXPENSE

Mail claims to the plan's program administrator:

NEBCO
144 Metro Center Blvd. Suite 1
Warwick, RI 02886-1706
866-286-8247

PART A

Policy Number:	Policyholder:
Member Name	Relationship to Member:
Name of Claimant(if different)	Date of Birth
Mailing Address	Social Security No.
Name and Address of Attending Physician/Dentist	

Part B	Date of Accident	Place of Accident / Facility Name
	Diagnosis	Type of Sport (if applicable)
	Describe the Accident	
	What part of the body was injured?	Which Side? R L (if applicable)
	At the time of the accident, was the injured person involved in an activity sponsored and supervised by the policyholder? Yes No	
	Name of the Supervisor	Was he / she a witness to the accident? Yes No
	Policyholder Verification Name Title	Date

Part C

Name of Member		Social Security #	Relationship: Father Mother Guardian Other	
Address (Number) Street (Lot or Apt. No.)		City	State	Zip Code
Area Code – Home Telephone Number		Area Code – Work Telephone & Extension		
Occupation of Father or Male Guardian	Place of Employment	Employer: Area Code – Phone Number		
Occupation of Mother or Female Guardian	Place of Employment	Employer: Area Code – Phone Number		

Do you have any other health and/or accident insurance plan (other than this plan)?
Claimant: Yes No Father: Yes No Mother: Yes No Guardian: Yes No

Is the injured person covered by other health and/or accident insurance plan?

Name of other health and/or accident insurance company Address Policy Number

INCLUDE ITEMIZED BILLS FOR MEDICAL TREATMENT AND YOUR PRIMARY INSURANCE CARRIER(S) BENEFIT SUMMARIES

(AUTHORIZATION MUST BE COMPLETED BY CLAIMANT, OR PARENT OR GUARDIAN IF CLAIMANT IS A MINOR)

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance or reinsuring company, or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of claimant and any other non-medical information of claimant to give ZURICH AMERICAN INSURANCE COMPANY or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of this Authorization will be used by ZURICH AMERICAN INSURANCE COMPANY to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by ZURICH AMERICAN INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request a copy of this Authorization. I AGREE that a photographic or photostatic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim

Signature of Member, or Parent or Guardian if Claimant is a minor Date

ATTENDING PHYSICIAN'S STATEMENT

Complete section below in full or attach a complete itemized statement of charges and statement of diagnosis.

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name: _____ Date of Birth _____

1. Diagnosis (describe nature of injury) . _____

_____

_____

2. Is condition the result of Illness Accident What date did accident occur? _____

If injury, how do you understand accident occurred? _____

_____

_____

3. Has the patient had treatment for the same or related condition before? Yes No If yes, when and by whom?

_____

_____

4. On what date were you first consulted for this condition? _____

Give dates of treatment: Office: _____

5. If hospitalized, give name and address of hospital and dates of confinement:

_____

Name Address Dates - From/To

_____

Name Address Dates - From/To

6. If surgery performed, please describe: _____

_____

7. Prognosis: _____

I hereby authorize Zurich American Insurance Company or its representative to inspect all x-ray pictures, clinical records and to obtain full information, including etiology and prognosis, or other data that may be in my possession or under my control, and to make copies of same or any portion thereof, pertaining to:

_____

(Name of Patient)

Signed _____

(Degree) (Social Security or Tax ID No.)

Date _____ Phone _____ Fax _____

Address _____

(City) (State) (ZipCode)

FRAUD STATEMENT

ALASKA: "A person who knowingly 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: "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."

ARKANSAS: "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.

CALIFORNIA: "For your protection California law requires the following to appear on this form: Any person who knowingly present 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."

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."

DELAWARE: "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."

WASHINGTON D.C.: "WARNING: 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 were provided by the applicant."

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."

IDAHO: "Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

I**NDIANA**: "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

KENTUCKY: "Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

LOUISANA: "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."

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 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."

NEW JERSEY: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." Substantially similar language must be approved by the DOI.

NEW MEXICO: "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 civil fines and criminal penalties.

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 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."

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."

OKLAHOMA: "WARNING: Any person who knowingly, 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: “I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact or material thereto commits a fraudulent insurance act which is a crime and such person may be guilty of insurance fraud.”

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."

TENNESSEE: "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."

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."

VIRGINIA: "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."

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."

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."

All claims must be remitted via mail to the plan's program administrator:
NEBCO
144 Metro Center Blvd. Suite 1
Warwick, RI 02886-1706
866-286-8247

MCM DISMEMBERMENT CLAIM FORM

NAME OF MEMBER:	NAME OF CLAIMANT IF DIFFERENT:	POLICY NO.:

ADDRESS OF CLAIMANT:	CERTIFICATE NUMBER:

HOME TELEPHONE NUMBER:	CELL PHONE NUMBER:	DATE OF BIRTH

OCCUPATION: (DESCRIBE DUTIES)

IS THERE A CLAIM UNDER COMPENSATION ACT? ☐ YES ☐ NO	NAME OF CARRIER:	DATE LAST WORKED: ☐A.M. ☐P.M.	HAVE YOU RETURNED TO WORK? (IF YES, GIVE DATE) ☐ YES ☐ NO

DATE ACCIDENT OCCURRED OR SICKNESS BEGAN:	NATURE OF INJURY OR SICKNESS:

IF ACCIDENT – DESCRIBE HOW AND WHERE OCCURRED:

IF SICKNESS – DATE SYMPTOMS FIRST NOTICED:	HAD THIS SICKNESS CAUSED YOU PREVIOUS TROUBLE? ☐ YES ☐ NO (IF YES, WHEN?)

NAME OF ATTENDING PHYSICIAN:	ADDRESS:	DATE FIRST TREATED:

OTHER PHYSICIANS CONSULTED: (NAME AND ADDRESS)

HAVE YOU BEEN CONFINED TO A HOSPITAL? ☐ YES ☐ NO (IF YES, NAME AND ADDRESS)

DATE ADMITTED TO HOSPITAL:	DISCHARGED:	WHEN DO YOU EXPECT TO RESUME LIGHT WORK:	WHEN DO YOU EXPECT TO RESUME USUAL DUTIES:

OTHER INSURANCE (LIFE, ACCIDENT, DISABILITY, HOSPITAL OR MEDICAL EXPENSE: (STATE NAMES OF COMPANIES OR ASSOCIATIONS AND AMOUNT IN EACH.)

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PERSON TO FURNISH ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL OR MEDICAL RECORDS REGARDING _____ _____ (CLAIMANT).

I HEREBY AUTHORIZE ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE TO RELEASE THE INFORMATION DESCRIBED ABOVE TO ANY EXPERT, INVESTIGATOR, PHYSICIAN, MEDICAL PRACTICIONER, HOSPITAL, MEDICAL OR MEDICAL RELATED FACILITY, INSURANCE COMPANY, REINSURER, PLAN ADMINISTRATOR, PLAN SPONSOR OR EMPLOYER FOR THE PURPOSE OF INVESTIGATING AND/OR ADJUDICATING MY CLAIM. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE OF MEMBER: _____ DATE _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

NAME OF PATIENT:	**AGE:**
NATURE OF SICKNESS OR INJURY: (DESCRIBE COMPLICATIONS, IF ANY)	
DATE ACCIDENT OCCURRED OR SYMPTOMS APPEARED:	DATE PATIENT CONSULTED YOU FOR THIS CONDITION:
HAS PATIENT EVER HAD SIMILAR CONDITION? ☐ YES ☐ NO (IF YES, WHEN, DESCRIBE)	
DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION:	
NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE : (DESCRIBE FULLY)	CHARGE: $ DATE PERFORMED:
DATES OF TREATMENT: OFFICE: HOME: HOSPITAL:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO (IF DISCHARGED, GIVE DATE)
IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL:	DATE ADMITTED: DATE DISCHARGED:
HOW LONG AS OR WILL PATIENT BE TOTALLY DISABLED? (UNABLE TO WORK) FROM: THROUGH:	HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? FROM: THROUGH:
IF SICKNESS, WAS PATIENT, CONFINED TO HOUSE: ☐ YES ☐ NO (IF YES, GIVE DATES) FROM: THROUGH:	
REMARKS:	

SIGNATURE OF DOCTOR: _____ DATE: _____

PHONE:_____FAX:_____

TO BE COMPLETED ONLY FOR LIMB AMPUTATIONS BY ATTENDING PHYSICIAN

1. Which limbs were severed or amputated?
   _____
   _____
2. State the dates on which the severance or amputation occurred._____
3. State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost.
   _____
   _____
4. State the cause of the amputations._____
5. Did the patient ever consult you before? If so please state the dates and the ailments for which you attended, treated, or examined._____
   _____
   _____
   _____
6. Please give the names of other physicians who have attended this patient, and the dates of their first and last treatments as reported to you._____
   _____
7. Was the injury described solely responsible for the loss._____
8. If not, give the particulars of any contributing cause or causes
   _____
   _____
   _____

TO BE COMPLETED ONLY FOR LOSS OF VISION BY ATTENDING PHYSICIAN

1. Give the dates you first determined vision was irrecoverably reduced to 20/200 or less with correction and the vision then remaining in each eye.

   Date:

   O.D.V. Uncorrected_____ Corrected
   O.S.V. Uncorrected_____ Corrected

2. Give the dates and vision found on last eye examination.

   Date:

   O.D.S. Uncorrected_____ Corrected
   O.S.V. Uncorrected_____ Corrected

3. State the cause of the loss of vision:

4. Indicate whether recovery or useful vision is possible by operation or treatment.

   O.D. Operation Treatment
   O.S. Operation Treatment

Signed_____
Attending Physician
Address_____Phone Number_____
_____

All claims must be remitted via
mail to the plan's program administrator:
NEBCO
144 Metro Center Blvd. Suite 1
Warwick, RI 02886-1706
866-286-8247

ZURICH®

MCM PROOF OF DEATH CLAIM FORM

☐ PERSONAL INSURANCE ☐ GROUP INSURANCE PART I (TO BE COMPLETED BY THE MEMBER/BENEFICIARY)

NAME OF DECEASED:	DATE OF BIRTH:	POLICY /CERTIFICATE NO.:
ADDRESS OF DECEASED:	POLICY ISSUED TO:	OCCUPATION OF DECEASED:

DATE OF ACCIDENT: (MONTH) (DAY) (YEAR)

HOUR: A.M. P.M.

WHERE DID THE ACCIDENT HAPPEN:

HOW DID THE ACCIDENT HAPPEN:

WHAT WAS THE DECEASED DOING AT THE TIME OF THE ACCIDENT:

WHAT INJURIES WERE RECEIVED:

STATE NAMES AND ADDRESSES OF ALL EYEWITNESSES TO ACCIDENT:

NAME OF HOSPITAL:

STAY IN HOSPITAL:
FROM: TO:

NAME AND ADDRESS OF DOCTORS ATTENDING THE DECEASED FOLLOWING THE ACCIDENT:

DOCTOR: _____ ADDRESS:
DOCTOR: _____ ADDRESS:
DOCTOR: _____ ADDRESS:
DOCTOR: _____ ADDRESS: _____

WAS THIS ACCIDENT REPORTED TO THE POLICE DEPARTMENT: YES NO IF YES, PLEASE INDICATE POLICE DEPT. NAME:

WAS INQUEST HELD? ☐ YES ☐ NO IF YES, PLEASE ATTACH CERTIFIED COPY OF VERDICT

WAS AUTOPSY HELD? ☐ YES ☐ NO IF SO, WHO CONDUCTED THE AUTOPSY (NAME AND ADDRESS)

WHAT WAS THE DECEASED'S BUSINESS OR OCCUPATION AT THE TIME OF THE ACCIDENT?

EMPLOYER?

DID DECEASED HAVE ANY CHRONIC DISEASE, PHYSICAL DEFECTS OR DEFORMITIES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

LIST OTHER APPLICABLE HEALTH, ACCIDENT, OR LIFE INSURANCE:
COMPANY: _____ POLICY NO.: _____ PRINCIPAL SUM: _____
COMPANY: _____ POLICY NO.: _____ PRINCIPAL SUM:
COMPANY: _____ POLICY NO.: _____ PRINCIPAL SUM: _____

WHAT AMOUNT ARE YOU CLAIMING:

DO YOU CLAIM AS:
☐ BENEFICIARY ☐ ADMINISTRATOR ☐ EXECUTOR

DATE OF BIRTH OF BENEFICIARY:

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PERSON TO FURNISH ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL OR MEDICAL RECORDS REGARDING _____ DECEASED.

I HEREBY AUTHORIZE ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE TO RELEASE THE INFORMATION DESCRIBED ABOVE TO ANY EXPERT, INVESTIGATOR, PHYSICIAN, MEDICAL PRACTICIONER, HOSPITAL, MEDICAL OR MEDICAL RELATED FACILITY, INSURANCE COMPANY, REINSURER, PLAN ADMINISTRATOR, PLAN SPONSOR OR EMPLOYER FOR THE PURPOSE OF INVESTIGATING AND/OR ADJUDICATING MY CLAIM. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE:	DATE:
ADDRESS:	
WITNESS:	DATE:
ADDRESS:	

STATEMENT OF ATTENDING PHYSICIAN

In relation to the death of _____, of _____
(name) (address)

1. How long has the Insured been your patient?

2. Please give the names of other physicians who have attended this patient, and the dates of their first and last treatments as reported to you

   Names:_____ Dates of Treatment:_____
   _____
   _____
   _____

3. Date of Death _____Month_____Day_____Year_____Hour_____

4. What was the primary cause of death?_____ natural causes_____, or accident _____

5. Date of accident _____Month_____Day_____Year_____Hour_____

6. On what date did you first attend deceased for the above condition? Month_____ Day_____Year_____

7. Describe his/her condition at that time? _____

8. Between what dates did you treat deceased? From_____To_____

9. How did the accident occur? _____

10. What was the precise nature and extent of injuries? (Describe fully all visible evidence)_____

11. What was the secondary or contributory cause of death?_____

12. Did any disease cause, other than the injury referred to, operate as a complication, or contribute to produce death?_____
    If so, what?_____

13. Was an alcohol and/or drug screen performed? No_____Yes_____

14. Was the Insured confined in a hsopital? No_____Yes_____

From:_____To_____

_____ _____
Attending Physician Signature Date

_____
Street

_____
City, state, zip code

_____
Telephone Number Fax