Accident Benefits

ACE Accidental Death Claim Form

Adventist Risk Management, Inc.
12501 Old Columbia Pike - Silver Spring, MD 20904
TEL: 1 (888) 951-4ARM (4276) | FAX: (301) 453-7060
EMAIL: claims@adventistrisk.org

How to File a Claim

1. Complete all sections of the attached claim form.
2. Attach the following documents:
    - All medical bills and receipts relating to the incident.
    - Police report, if applicable.
    - Newspaper clippings regarding the incident, if available.
    - Copy of the final death certificate.
    - Autopsy report.
3. Send the completed and signed claim form and all required documents to:

Adventist Risk Management, Inc.
Claims and Legal Services
12501 Old Columbia Pike, Silver Spring,
MD 20904 Email:
claims@adventistrisk.org
Phone: 1 (888) 951-4ARM (4276)
Fax: (301) 453-7060

4. Retain a copy for your records.

Please familiarise yourself with the summary of benefits provided by your employer. There are provisions, limitations, and exclusions in the policy. ACE Insurance Company makes the final determination on payment or denial of all claims.

A CLAIM ADJUSTER WILL CONTACT YOU IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

ACE American Insurance Company

Accidental Death Proof of Loss

POST TO:
Claims & Legal Services
Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20904
Tel: (301) 453-7400
Fax: (301) 453-7060
E-mail: claims@adventistrisk.org

Name of Group:

Policy Number:

In addition to the claim form, the following items are required:
(1) A Certified Copy of the final death certificate;
(2) Your company's enrolment benefits form and Beneficiary Designation;
(3) Confirmation of employee's Principal Sum and current premium payment;
(4) The Police Report, any Autopsy Report, and any newspaper clippings.
(5) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of trip, destination to and from trip, and confirmation that trip was authorised by the company.

Insured	Certificate Number(s)

Facts Concerning Insured

Full Name	Social Security Number

Address

Date of Birth	Place of Birth	Date of Death

Occupation	Name of Employer

Employer's Address

Beneficiary

Name	Relationship to Deceased	Date of Birth	Social Security Number

Address	Telephone:

Statements Regarding the Accident

Date of Accident	Place

State Specifically how Accident Happened

Did the accident occur in the course or during deceased's employment?
☐ Yes ☐ No If "yes", has there been, or will there be, a claim filed for Worker's Compensation? ☐ Yes ☐ No

Name of Worker's Compensation Carrier

Address

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

To be completed on all claims

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

Name of court holding hearing

Address

Was an autopsy conducted? ☐ Yes ■ No If "yes", complete the following and attach certified copy of report.

Name of person conducting autopsy	Title

Address

First physician attending deceased after injury

Name:	Address:

Previous medical history

Was deceased treated for any medical conditions within five years prior to the accident?
☐ Yes ☐ No If "yes", list physician(s) in attendance below

1	Name	Address
	Medical Condition	Dates of treatment
2	Name	Address
	Medical Condition	Dates of treatment
3	Name	Address
	Medical Condition	Dates of treatment

Other insurance on life of deceased

Company name	Address	Amount
Company name	Address	Amount
Company name	Address	Amount
Company name	Address	Amount

By signing below I hereby certify that these statements and answers are true and correct to the best of my knowledge and belief.

Signature of beneficiary/claimant	Dated

Address

I authorise any doctor, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to _____, deceased, to give ACE American Insurance Company or its legal representative any and all such information for the purpose of evaluating a claim for benefits.

I understand the information obtained by use of this authorisation will be used by ACE American Insurance Company to determine eligibility for benefits under the policy insuring said deceased. Any information obtained will not be released by ACE American Insurance Company to any person or org anization except to reinsuring companies, policyholders or other persons or organisations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, permitted or as I may further authorise.

I agree that a photographic copy of this Authorisation shall be a valid as the original.
I agree this Authorisation shall be valid for two years from the date shown below.
I understand that I or my authorised representative may request a copy of this authorization.
I understand that I or my authorised representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured, Authorised Representative, Beneficiary or Next of Kin:	Dated

Address:

Fraud Warnings: Certain states in the USA require specific state mandated fraud language to be included on all claims forms while other states in the USA use a generalized fraud stated. ACE USA Accident & Health has adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrolment forms.

District of Columbia Generic 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 was provided by the applicant.

The following states have required us to use state-specific language as follows:

California
For your protection, California law requires the following to appear on this form:
Any person who knowingly presents 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.

Florida
Any person who knowingly and with intent in 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.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania
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 and subjects such person to criminal and civil penalties.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.