

#### BUSINESS TRAVEL ACCIDENTAL DEATH AND DISMEMBERMENT CLAIM FORM

### IMPORTANT INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

To expedite claim processing, the attached claim forms need to be fully completed and the following instructions must be adhered to. Each claim will be evaluated based on the terms and conditions of the insurance policy. The Insurance Company reserves the right to request additional information and/or documents to help us make this evaluation. The acceptance of these forms by the Insurance Company is not an admission of coverage under an insurance policy.

# Part I – Employer's Statement

Form must be completed in its entirety and certified by an official representative of the employer or the plan.

Please provide the employee's itinerary or any other information that demonstrates that the employee was on the business of the policyholder at the time of the accident.

Please provide proof of salary (attach W2 or commissions, if applicable)

Please provide the beneficiary designation forms on file with the policyholder, if any. If none on file, the official representative shall certify to that fact on the claim form.

#### Part II - Claimant's Statement

To be completed by claimant or beneficiary in its entirety

Please furnish any newspaper accounts or other pertinent information regarding the claim.

# Part III – Attending Physician's Statement (required for accidental dismemberment claims)

Attending physician must complete this form. Any expense for completion of the form will be paid for by the claimant.

### Miscellaneous - All Claims

Required documents other than claim form

Certified true copy of death certificate (Accidental Death Claim)

Police Report (if applicable)

Autopsy/Post Mortem & Toxicology report (if applicable)

All relevant medical reports

If the claim proceeds are payable to an estate, Part II must be completed by the executor or administrator of the estate. A copy of the court document appointing the executor or administrator must be attached to this form.

If any designated beneficiary is a minor, Part II must be completed by the custodian or guardian. A copy of the court document appointing the guardian or a similar document must be attached to this form.

For a foreign death, the official death certificate and the Report of the Death of an American Citizen Abroad form must be attached to the claim form.

Mail Claim Forms to: AXIS Accident & Health

Attn: AXIS Claims

1 University Square Drive, Suite 200

Princeton, NJ 08540 Fax: (800)-419-8963



Date\_\_\_/\_\_/\_\_

PHONE NO.

Mail to: AXIS Accident & Health

Attn: AXIS Claims

1 University Square Drive, Suite 200

Princeton, NJ 08540 Toll Free: (888)-870-2947 Fax: (800)-419-8963

Email: <u>USClaims.AccHealth@AXISCapital.com</u>

### **BUSINESS TRAVEL ACCIDENT INSURANCE**

# PART I - Employer's Statement

SIGNED (Authorized person) \_

NAME

Accidental Death & Dismemberment Claim Form for EMPLOYEE or DEPENDENT

Group Policyholder/Employer Name:  Northwestern University								
Group Policyholder/Employer A	ddress:							
Name of Insured Employee/Par	rticipant:				Date of Birth:		Social Security Number:	
Name of Deceased or Injured. (	(if different fro	m above:)			Date of Birth:		Social Security Number:	
Relationship to Employee:			Telephone Number:	Employee Class	S #:	Location:		
Address:						1		
Did the Employee Select Family	y Coverage? (	if applicable):		Marital Status:	Diverse d	Othor		
☐Yes ☐ No Please list the dates of birth and	d names of th	e Employee's Depe	□Married endent Children (if	□Single any):	□Divorced	□Other		
2								
Date of Injury:	te of Injury: Employee Status on Date of Injury							
Employee was:	□Full time		□Salaried		□Exempt		□Commissioned	
Employee was.	□Part time		□Hourly		□Non-exempt		□Other (Please explain):	
Effective Date of Coverage for	Employee:			Employee Salary on Date of Death:				
Employee Occupation/Title/Pos	sition:				Date Employment Commenced:			
Business Travel Accident Policy Number :				Please describe the purpose and location of the business trip, and include the dates.				
Amount of Coverage:								
Beneficiary Information								
Is Beneficiary Designation Card on file? □Yes □No If "Yes", a copy must be submitted to us.								
Is there an Assignment on file? □Yes □No If "Yes", a copy must be submitted to us.								
Employer Certification								
I understand that any person w or misleading information may be				any insurance co	mpany files a cl	aim containing a	ny materially false, incomplete	

TITLE

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### PART II - Claimant's Statement

Accidental Death & Dismemberment Only Claim Form for EMPLOYEE or DEPENDENT

<b>INSTRUCTIONS</b> : Complete this form if you are applying for death or dismemberment benefits due to an Accident. If a question does not apply, please mark "N/A".							
GROUP POLICYHOLDER/EMPLOYER NAME: Northwestern University							
<u> </u>	Social Security Number						
	Has a Workers Compensation claim been filed? ☐ Yes ☐ No If "Yes", what is the status of the claim?						
Relationship to Employee:  □ Spouse/Domestic Partner □ Child							
On what date did the accident happen? Where did the accident happen? City State Please describe all injuries received.							
Did accident result in death?   Yes No If "Yes", on what date?  Describe in detail how the accident occurred.							
Name and address of law enforcement agency involved (Please submit copy of Poli	lice Accident Report).						
List name/address/phone # of all physicians consulted for this injury/death.							
List name/address/phone # of all hospitals consulted.							
Did the deceased/injured have any chronic disease or physical defect or deformity? □Yes □No If "Yes", describe in detail:							
Was autopsy performed? ☐ Yes ☐ No If "Yes", provide name/address/telephone number of coroner, if known	Was an inquest held? ☐ Yes ☐ No If "Yes," verdict?						
Name of Beneficiary Address	Telephone Social Security Number: Number						
Your date of birth In what capacity are you making claim? (Note: if other than beneficiary, attach appropriate legal documents substantiating your authority.)							
Your address	and						
Telephone number (if different from beneficiary).							
Your relationship to deceased or injured Your Social Security Number							
I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the deceased or insured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV and alcohol/drug records to release all such records in their entirety to AXIS Insurance Company, and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time be sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier. I understand that by signing this form I may be authorizing the use and disclosure of my confidential protected health information to AXIS Insurance Company.							
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.							
SIGNATURE OF PERSON COMPLETING THIS FORM	DATE						

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# PART III - Attending Physician's Statement

Required for all accidental dismemberment claims.

Attending physician must complete this form. Any expense for completion of the form will be paid by claimant.										
Name of Patient:			Date of Birth:		Address (Street, City, State					
When did accident h	, Year)	When did patier	When did patient first consult you for this condition? (Month, Day, Year)							
Nature of injury: Please explain in complete detail, including all diagnoses, any dismemberment or loss of use; the cause or incident causing the injury, and all affected body parts.										
If injury resulted in severance of a body part, please indicate the precise location of the severance:										
Did injury result in the total and irrecoverable loss of hearing in both ears? □Yes □No Date of loss:										
Did the injury result i	e injury result in:									
☐ Paralysis			□ Quadriplegia		□ Paraplegia		□ Hemiplegia			
In your opinion, was any disease, infection, bodily or mental infirmity an underlying cause in the loss(es) indicated above?										
If an operation is contemplated, give approximate date and nature of the operation:										
In your opinion, did the loss(es) result from any self-inflicted injury or attempted self-destruction?   Yes  No										
If injury resulted in loss of sight, was the loss total and irrecoverable?										
O.D.	O.S.		O.D.	o. O.S.						
Do you believe vision can be restored in whole or in part by treatment or operation?  So No										
Was patient confined to a hospital? □Yes □No If "Yes", give name and address of hospital and dates of confinement:										
Treatment										
Date of first visit	Dates of Subsequent Visits									
Is patient still under your care for this condition?   Yes  No										
If discharged, give date of discharge:										
Signature of Attending Physician Physician's Name (P			Please Print)		Degree Telephone		Date			
Street Address:			City or Town	City or Town State or Province			Zip Code			



#### FRAUD STATEMENTS



Important Notice

In General, and specifically for residents of Arkansas, Louisiana, Rhode Island and 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.

- For Residents of Alabama: 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 restitution fines and confinement in prison, or any combination thereof.
- For residents of 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.
- For residents of the District of Columbia: <u>WARNING</u>: 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.
- For residents of 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.
- For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other
  person files an application for insurance 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.
- For residents of Maine, Tennessee, Virginia and 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.
- For residents of Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a 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.
- For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- For residents of 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.
- For residents of 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.
- For residents of 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.
- For residents of 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.
- For residents of 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.