Beazley Insurance Company, Inc.
Administrative Services provided by:
Administrative Concepts, Inc.
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: 800-508-9238

DEATH CLAIM FORM
Accidental Death and Dismemberment

INSTRUCTIONS – PLEASE READ CAREFULLY
Important instructions for completing your Accidental Death Claim.

IMPORTANT NOTE: Completed Claim Form and requested information including a certified copy of the death certificate must be submitted via US Mail.

Section 1 and 1B – Insured Information/Deceased Information

- If Insured is the deceased, section should be completed by the Beneficiary (must be signed by all named Beneficiaries)
- If the deceased is a **Dependent**, section should be completed by the Insured
- Complete 1B if the deceased is not the insured member.

Section 2 – Accident Information

- If the **Insured** is the deceased, section should be completed by the Beneficiary (must be signed by all named Beneficiaries).
- If the deceased is a **Dependent**, section should be completed by the Association Member
- Additionally, please furnish any newspaper accounts, police or motor vehicle reports and/or other pertinent information regarding the Accident in order to facilitate consideration of the claim.
- For Seat Belt benefit, a copy of the police report of the Accident must be provided or a certification, in writing, by the investigating officer(s) that states the seatbelt was used properly

Section 3 and 3B – Beneficiary Statement

- Section must be completed by beneficiary or beneficiaries
- Section 4B must be signed by all beneficiaries.
    - If more than one beneficiary, each beneficiary can either sign and date the one form, or complete separate forms that include their date of birth and Social Security number.
    - Guardian must sign for minor child(ren) if applicable

Section 4 – Claimant Signature

Section 5 – Employer Statement (Applies to Employer Group Coverage only)

SECTION 1: INSURED INFORMATION				
Name of Insured:			Social Security Number (SSN):	Date of Birth:
Name of Employer Group or Association:		Group Number:		Occupation:
Insurance Effective Date:	Phone: ( )	E-Mail Address:		
Street Address	Apt. No.	City	State	Zip Code

SECTION 1B: DECEASED INFORMATION				
Name of Deceased:		Date of Birth:	SSN:	
Relationship to Insured:		Occupation:		
Street Address	Apt. No.	City	State	Zip Code

SECTION 2: ACCIDENT INFORMATION			
Date of Accident:	Time of Accident:	Date of Death:	Time of Death:
Location of Accident:			
Describe in detail how the Accident occurred:			
Describe all Injuries:			
Maximum Benefit Amount for Deceased: Accidental Death: $			
For Seat Belt Benefit (if applicable)			
Was the insured operating or riding as a passenger in Private Passenger Automobile at the time of the accident? ☐Yes ☐No			
Was the insured wearing a seatbelt at the time of the accident? ☐Yes ☐No			
In the case of a child, was the child properly secured in an appropriate child restraint system, as required by state law and approved by the National Highway Traffic Safety Administration at the time of the accident? ☐Yes ☐No			
List all investigating authorities. (Use additional sheet if necessary.)			
Law Enforcement Agency Name:	Case #: *(Submit a copy of the accident report, if applicable.)*		
Investigating Officer Name & Title:	Phone: ( )		
Law Enforcement Agency Street Address	City	State	Zip Code
Inquest Held: ☐Yes ☐No *If yes, attach a copy of verdict.*			
List all witnesses to the accident. (Use additional sheet if necessary.)			
Witness Name:	Phone: ( )		
Street Address	Apt. No.	City	State Zip Code
Witness Name:	Phone: ( )		
Street Address	Apt. No.	City	State Zip Code
Witness Name:	Phone: ( )		
Street Address	Apt. No.	City	State Zip Code
List all physicians & surgeons who attended the Insured for Injuries incurred in the Accident. (Use additional sheet if necessary.)			
Physician Consulted:	Phone: ( )		
Street Address	City	State	Zip Code
Physician Consulted:	Phone: ( )		
Street Address	City	State	Zip Code
Physician Consulted:	Phone: ( )		
Street Address	City	State	Zip Code
Hospital Consulted for this injury:	Phone: ( )		
Street Address	City	State	Zip Code
Autopsy Performed: ☐Yes ☐No *If yes, attach a summary of autopsy report.*			

SECTION 3: BENEFICIARY INFORMATION FOR ACCIDENTAL DEATH CLAIM *(Please attach additional sheet if necessary.)*		
Beneficiary Name:	Relationship to Insured:	
Beneficiary's Full Address:		
Phone Number: ( )	Date of Birth:	Social Security or Tax ID Number:

Beneficiary Name:		Relationship to Insured:
Beneficiary's Full Address:		
Phone Number: ( )	Date of Birth:	Social Security or Tax ID Number:
Beneficiary Name:		Relationship to Insured:
Beneficiary's Full Address:		
Phone Number: ( )	Date of Birth:	Social Security or Tax ID Number:

If any of the above beneficiaries are minors, please complete the following information:
(Include Guardianship/Custodian papers, if applicable.)

Beneficiary Name:	Guardian/Custodian Name:	Phone Number: ( )
Full Address of Guardian/Custodian:		

3B: BENEFICIARY SIGNATURE(S) FOR ACCIDENTAL DEATH CLAIMS *(This form must be signed.)*

AUTHORIZATION AND ACKNOWLEDGMENT (Please see below to read special notices required by state law.)

I hereby certify that the above information is true and correct to the best of my knowledge.

X _____ _____
Signature of Beneficiary (#1) Date Signed

X _____ _____
Signature of Beneficiary (#2) Date Signed

X _____ _____
Signature of Beneficiary (#3) Date Signed

SECTION 4: CLAIMANT SIGNATURE *(This form must be signed.)*

AUTHORIZATION AND ACKNOWLEDGMENT (Please see below to read special notices required by state law.)

I hereby certify that the above information is true and correct to the best of my knowledge.

X _____ _____
Signature of Person Completing Form Date Signed

SECTION 5: EMPLOYER STATEMENT *(This section must be signed.)*

Employer Name:		Employer FEIN:	
If Branch or Affiliate, Name of Parent Company:			
Street Address	City	State	Zip Code
Printed Name of Authorized Person:		Title:	
Phone Number: ( )	Fax Number: ( )	Email:	
Employee Name:	Employee DOB:	Employee SSN:	
Employee Job Title:	Date of Employment: _____ /_____ /_____	Insurance Effective Date: _____ /_____ /_____	
Do you have a Beneficiary Designation form on file for the Insured? ☐No ☐Yes *(Submit a copy of Beneficiary Designation form, if available.)*		Date of Beneficiary Designation:	

I certify that I have reviewed the above information and the employee named above has been full time active employee for whom premiums have been paid. I hereby certify that the above information is true and correct to the best of my knowledge.

X _____ _____
Authorized Employer Representative Signature Date Signed

FRAUD WARNING

Any person who knowingly 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 thereto may be guilty of committing a fraudulent insurance act, which is a crime.

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, Louisiana, Rhode Island, 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.

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.

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.

District of Columbia - 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.

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

Indiana - 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.

Kansas – It is unlawful to commit a fraudulent insurance act, which means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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.

Maine, Tennessee, Virginia, 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.

Maryland - 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 is guilty of a crime and may be subject to fines and confinement in prison.

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.

New Mexico – Any person who, with intent to defraud or knowing that he or she 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.

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 false, incomplete or misleading information is guilty of a felony.

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.

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.

Vermont - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.