



# ACCIDENT & HEALTH CLAIM FORM MULTI-STATE

P.O. Box 5670  
Cortland, NY 13045  
Phone: (800) 822-3747  
Fax: (607) 756-5967  
Loss\_notice@mcneilandcompany.com

## CLAIMANT'S INFORMATION/STATEMENT

Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Today's Date
Address			Home Phone (    )	
City	State, Zip		Cell Phone (    )	
Email Address			Social Security Number	
Membership Status in Emergency Service Org <input type="checkbox"/> Volunteer <input type="checkbox"/> Paid Career <input type="checkbox"/> Aux <input type="checkbox"/> Junior		Marital Status		Dependent Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Employer at Time of Injury/Illness		Date of Hire	Regular, Full Time Occupation	
Employer's Address			Employer's Phone (    )	
City	State, Zip		Average Monthly Gross Income	
Date and Time of Accident or Commencement of Illness	Any Time Lost from Full Time Job? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did You File with Workers' Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Where Did the Accident or Exposure to Illness Occur?	How Did the Accident or Exposure to Illness Occur?			
What is Your Injury or Illness?	Details Regarding Missed Work Time: Date of First Day Missed: Date Returned for Partial Duty: Date Returned to Full Time Duty:			
Attending Physician's Name			Physician's Phone (    )	
Physician's Address		City	State, Zip	

I certify that the above information is true and complete to the best of my knowledge and belief.

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 McNeil & Co., Arch Insurance Company or their 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 identified herein. I authorize the policyholder, employer or benefit plan administrator to provide McNeil & Co., Arch Insurance Company or their representatives with financial and employment-related information.

- 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.

Claimant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR If the claimant is unable to sign

Authorized Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Claimant: \_\_\_\_\_

## EMERGENCY SERVICE ORGANIZATION CERTIFICATION

To be completed by an official of the Named Insured.

It may not be completed by the claimant or a member of the claimant's immediate family.

Name of Emergency Service Organization	Policy Number
Name of Certifying Official	Title
Email Address	Daytime Phone (      )
Was the Claimant a Member at the Time of the Accident or Exposure to Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the Claimant Involved in an Authorized Activity at the Time of the Accident or Exposure to Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the Claimant's Membership Status? <input type="checkbox"/> Volunteer <input type="checkbox"/> Paid Career <input type="checkbox"/> Auxiliary <input type="checkbox"/> Junior	

I certify that the above information is true and complete to the best of my knowledge and belief.

Official's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### STATE FRAUD STATEMENTS

**NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.**

**NOTICE TO ALABAMA APPLICANTS:** 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 or confinement in prison, or any combination thereof.

**NOTICE TO ARKANSAS, LOUISIANA, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA APPLICANTS:** 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.

**NOTICE TO COLORADO APPLICANTS:** 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.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** 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.

**NOTICE TO FLORIDA APPLICANTS:** 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 in the third degree.

**NOTICE TO KANSAS APPLICANTS:** 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, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication 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 commits a fraudulent insurance act.

**NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with the 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.

## STATE FRAUD STATEMENTS (CONTINUED)

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**NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:** 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.

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

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW YORK APPLICANTS:** 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.

**NOTICE TO OHIO APPLICANTS:** 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.

**NOTICE TO OKLAHOMA APPLICANTS: 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.

**NOTICE TO OREGON APPLICANTS:** Any person who, knowingly and with intent to defraud or facilitate a fraud against any insurance company or other person, submits an application, or files a claim for insurance containing any false, deceptive, or misleading material information may be guilty of insurance fraud.

**NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly and with the 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.