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 ☐ M ☐ F	Today's Date
Address			Home Phone ( )	
City	State, Zip		Cell Phone ( )	
Email Address			Social Security Number	
Membership Status in Emergency Service Org ☐ Volunteer ☐ Paid Career ☐ Aux ☐ Junior	Marital Status		Dependent Child(ren) ☐ Yes ☐ No	
Name of Employer at Time of Injury/Illness (Regular Occupation)		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? ☐ Yes ☐ No		Did You File with Workers' Comp? ☐ Yes ☐ No ☐ 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 (from Regular Occupation): 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?				☐ **Yes** ☐ **No**
Was the Claimant Involved in an Authorized Activity at the Time of the Accident or Exposure to Illness?				☐ **Yes** ☐ **No**
What is the Claimant's Membership Status?	☐ **Volunteer**	☐ **Paid Career**	☐ **Auxiliary**	☐ **Junior**

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

Official's Signature:______________________________ Date:______________

APPLICATION SIGNATURES & 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, 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 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.

NOTICE TO LOUISIANA 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 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 MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 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 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.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps, or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Application Signatures & State Fraud Statements

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS APPLICATION AND THAT THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

Applicant's Signature: ______________________________ **Date:** ______________

Name and title (please print): ______________________________

Insurance Broker's Signature: ______________________________ **Date:** ______________

(To be signed by someone who does not have access to funds)