BENEFITS BY McNeil&Co.

Statement of Beneficiary

McNeil & Company

Proof of Claim- Accidental Death

(No Liability is admitted by the issue of this form)

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

Any person who knowingly presents a false or fraudulent claim for payment of 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.

MAIL TO:
CLAIMS
McNeil & Company
PO Box 5670
Cortland, NY 13045

Fax: (607) 756-5967
loss_notice@mcneilandcompany.com

Insured	Certificate/Policy number(s)

Facts concerning deceased

Full Name:			
Last Name	First Name	M.I.	Social Security #

Home Address:

# and Street	City/Town	State	Zip Code

Date of Birth:	Place of Birth:	Social Security Number:
Occupation:	Name of Employer:	
Authorized Policyholder Representative(please print):	Signature:	Date:

Beneficiary

Name of Beneficiary:		
Last Name First Name M.I.	Social Security #	Date of Birth:

Address:

# and Street	City/Town	State	Zip Code

Relationship to Insured:	Telephone number:

Complete for all claims

Date of Accident:	Place accident occurred:

Describe how accident occurred:

Did the accident happen at work: Yes ☐ No ☐ Has a claim or will a claim be filed under worker's compensation? Yes ☐ No ☐

Name of worker's compensation carrier:

Address:

# and Street	City/Town	State	Zip Code

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:

# and Street	City/Town	State	Zip Code

To be completed on all claims

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

Name of court holding hearing:

# and Street	City/Town	State	Zip Code

Was an autopsy conducted Yes ☐ No ☐ If "yes", complete the following and attach a copy of the report

Name of person conducting autopsy:	Title:

Address:

# and Street	City/Town	State	Zip Code

First physician attending deceased after injury

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	

Other physicians attending deceased after injury

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	

Previous medical history

Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Medical Condition:	Dates of Treatment:
Name:	Degree:
Address:	
# and Street / City/Town / State / Zip Code	
Medical Condition:	Dates of Treatment:

Other Insurance on life of deceased

Company name:	Amount:
Address:	
# and Street / City/Town / State / Zip Code	
Company name:	Amount:
Address:	
# and Street / City/Town / State / Zip Code	

BY SIGNING BELOW I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSIGNMENT OF BENEFITS

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 the Insurance Company named above or its 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 Number identified above. If applicable, I authorize the policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original.

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.

Signature of beneficiary/ claimant	Dated
Address:	

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