BENEFITS BY McNeil&Co.

ACCIDENT & HEALTH CLAIM FORM
CANCER

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**	**Today's Date**
Address		**Home Phone** ( )
City	**State, Zip**	**Cell Phone** ( )
Email Address		**Social Security Number**
Name of Emergency Service Organization	**Marital Status**	**Dependent Child(ren)** ☐ Yes ☐ 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 of Cancer Diagnosis	**Any Time Lost from Full Time Job?** ☐ Yes ☐ No	**Did You File with Workers' Comp?** ☐ Yes ☐ No ☐ N/A
Cancer Diagnosis (type)	**Are you a volunteer or paid firefighter with another New York Department?** ☐ Yes ☐ No **If YES, Department name & service years:** **Are you filing benefits with this Department?** ☐ Yes ☐ No	
Details Regarding Disability (unable to actively volunteer): **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:_____

67 Main Street, PO Box 5670
Cortland, NY 13045
(800)822-3747
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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** ( )
Address	
City	**State, Zip**
Was the Claimant a Member at the Time of Cancer Diagnosis? ☐ **Yes** ☐ **No** **If NO, when was the claimant last an active member of the organization?**	
Does the Claimant have 5 or more years of service as an interior volunteer firefighter for the organization? ☐ **Yes** ☐ **No**	
Did the Claimant have a physical prior to becoming an Interior Firefighter? ☐ **Yes** ☐ **No** **Did the physical detect any evidence of Cancer?** ☐ **Yes** ☐ **No**	
Has the Claimant passed 5 annual fit tests? ☐ **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:_____

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 VIOLATION.