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

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 Arch Insurance Company 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.

Applicant's Signature: ______________________________ Date: ______________
Or, if the claimant is unavailable to sign, an authorized representative may sign on their behalf

Name and title (please print): ______________________________

Full Address: ______________________________

EMERGENCY SERVICE ORGANIZATION CERTIFICATION

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

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 Physical detect any evidence of Cancer? ☐ Yes ☐ No	
Did the Claimant have a physical prior to becoming an Interior Firefighter? ☐ Yes ☐ No	
Has the Claimant passed 5 annual fit tests? ☐ Yes ☐ No	
What is the Claimant's Membership Status? ☐ Volunteer ☐ Paid Career ☐ Auxiliary ☐ Junior	

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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.

Official's Signature: ______________________________ Date:______________

Name and title (please print): ______________________________

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

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.