Habitat for Humanity®

Chubb Group of Insurance Companies

ACCIDENT CLAIM FORM

PLEASE NOTE THAT THIS COVERAGE IS EXCESS OF ANY OTHER MEDICAL INSURANCE THAT YOU MAY HAVE WITH ANOTHER INSURANCE COMPANY. IF YOU HAVE OTHER COVERAGE, PLEASE SEND YOUR CLAIM TO THAT INSURANCE COMPANY FIRST.

Instructions:

1. **Complete both sides of the claim form — please print clearly or type.**
2. **Attach itemized bills.**
3. **If you have previously submitted this claim to your other insurance company, attach correspondence from that insurance company.**
4. **Retain copies for your records.**
5. **Affiliate President, Director or Team Leader must sign form.**

Full Name (Injured Person):	Social Security Number:
Street Address:	Telephone Number (INCLUDING AREA CODE):
City or Town, State, Zip:	Date of Birth:
Employer's Name:	Telephone Number:
Address:	Contact Person:
Habitat Affiliate's Name:	Physician's or Surgeon's Name:
Street Address:	Street Address:
City, State, Zip:	City, State, Zip:
Policy Number:	Telephone Number (INCLUDING AREA CODE):
When were you injured? Date: Time: A.M. P.M.	If Hospitalized, Name of Hospital:
When did you cease work? Date:	Hospital Address:
If Totally Disabled, Give Dates: From: To:	City, State, Zip:
When did or will you resume any part of your work? Date:	Hospital Confinement Dates: From: To:
Describe in detail how and where accident occurred: (Attach separate sheet, if necessary)	Describe Injuries:
Please list all insurance - Current Medical Insurance Company: Policy Number: Effective Date:	

CERTIFICATION OF NO OTHER INSURANCE

I, _____ hereby certify that I had no primary health insurance covering this loss.

Signed (Insured or authorized person) _____ Date: ____ / ____ / ____

Sworn and Subscribed before me on this _____ day of _____ , _____ .

_____ (Seal)
Notary Public

Mail directly to Habitat Claims Unit, c/o Chubb Group of Insurance Co., 600 Independence Pkwy., Chesapeake, VA 23327-4710 • TOLL FREE NUMBER: 1 (800) 252-4670

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

_____ _____

Signature of Volunteer

Signature of Affiliate President/Director/Team Leader
Telephone Number: _____

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to Federal Insurance Company, or its representatives, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature Date

PHYSICIAN'S REPORT
(To be completed by attending physician, excluding emergency room treatment)

Patient's Name:			
Nature of Injury (Describe complications, if any):			
Describe any other disease or infirmity affecting present condition:			
Give Dates of Treatments:		Office: Home: Hospital:	
Is patient still under your care for this condition?	Yes _____ No _____	Contemplated Discharge Date:	If Discharged, give date:
Amount of your bill for services to date:			
Was your patient disabled?	Yes _____ No _____	If Yes, Total _____ Partial _____	Able to return to work on (date) _____ Resumed work on (date) _____
Physician's Signature:		Date:	
Street Address:			
City:	State:	Zip:	
Phone Number (INCLUDING AREA CODE):			