CHUBB

Voluntary Accident Insurance

Designed for:

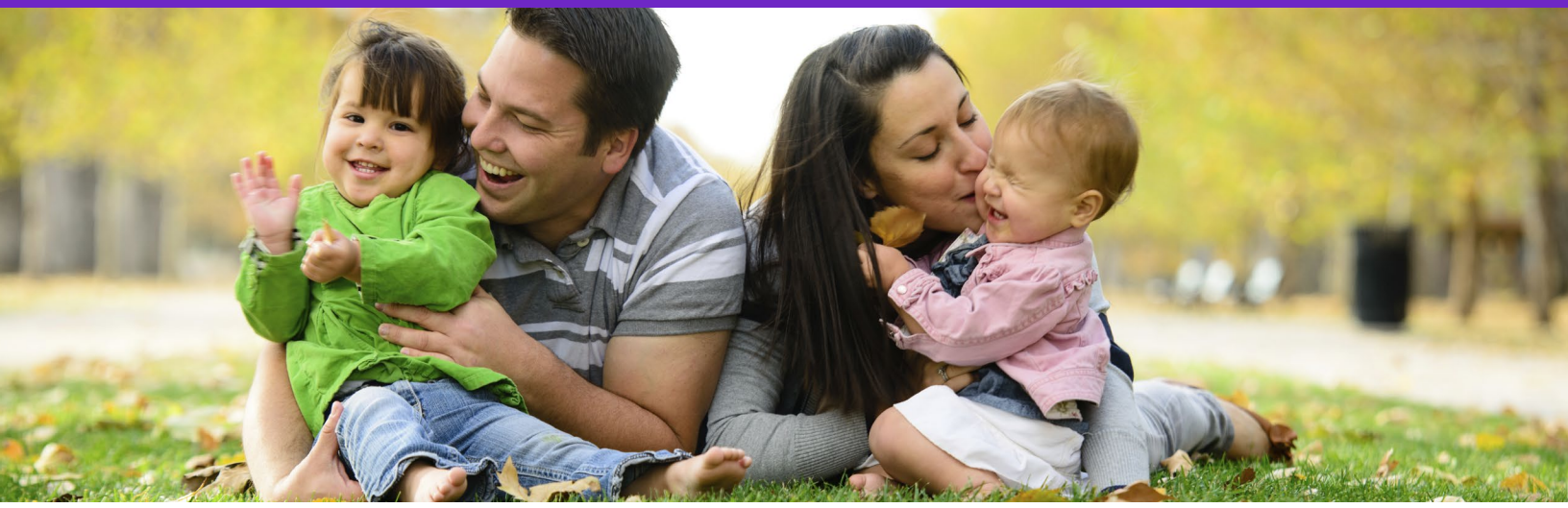
Employees of Chubb INA Holdings, Inc.

Underwritten by ACE American Insurance Company

Accidents Happen

This Valuable Insurance Coverage Can Help.

Despite careful planning and preparation, accidents happen. If they do, an accident insurance policy can help ensure that you or your family have access to the financial support you need to adapt or recover. Plus, these benefits are paid in addition to other insurance coverages — so they can help fill gaps or further strengthen your level of insurance protection.



Benefits & Features

This plan offers round-the-clock protection against covered accidents occurring on or off the job, at home, while traveling on business or pleasure by plane, train, automobile, or any other public or private air, land, or water conveyance, except as limited by the exclusions.

Eligibility

You may elect this insurance plan if you are an active, full-time employee of Chubb INA Holdings, Inc. scheduled to work a minimum of 24 hours per week.

If you elect coverage for yourself, you may also elect coverage for your spouse and unmarried children under 26 years old. Insurance may continue for any dependent child who reaches the age limit and has a mental or physical handicap that is expected to result in death or continued disability for at least 12 months. A child, for eligibility purposes, includes a natural child, adopted child, or stepchild who resides with you or depends on you for financial support.

Note: No eligible individual may be covered more than once under this plan. If you are covered as an employee, you cannot be covered as a spouse or dependent of another employee.

Highlights

- Accidental Death, Dismemberment, and Paralysis benefits can be purchased up to $750,000.
- Insurance protection available for you and your family.
- 24-hour, worldwide insurance protection including valuable travel assistance services.
- Affordable cost, payable through convenient payroll deductions.
- Additional benefits are included, such as: Exposure and Disappearance coverage, Common Accident benefit, Emergency Medical benefit, Emergency Medical Evacuation benefit, Rehabilitation benefit, Repatriation of Remains benefit, Seatbelt and Airbag benefit, and Special Education benefit.

Coverage

Accidental Death, Dismemberment, and Paralysis Benefits

If you or an insured family member are injured in a covered accident and suffer any of the losses shown in the *Schedule of Covered Losses* below within 365 days, we will pay the benefit amount shown for that loss. If more than one loss occurs in the same accident, only one benefit, the largest, will be paid. Benefits will be reduced at age 70.

Schedule of Covered Losses	
Covered Loss	**Benefit Amount**
Life	100% of the Principal Sum
Two or More Members	
Quadriplegia	
Paraplegia	75% of the Principal Sum
One Member	50% of the Principal Sum
Hemiplegia	
Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Uniplegia	

"Quadriplegia" means total Paralysis of both upper and lower limbs.

"Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body.

"Uniplegia" means total Paralysis of one lower limb or one upper limb.

"Paraplegia" means total Paralysis of both lower limbs or both upper limbs.

"Paralysis" means total loss of use. A Doctor must determine the loss of use to be complete and not reversible at the time the claim is submitted.

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Speech, and Loss of Hearing.

"Loss of Hand or Foot" means complete Severance through or above the wrist or ankle joint.

"Loss of Sight" means the total, permanent Loss of Sight of one eye.

"Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical, or artificial means.

"Loss of Hearing" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means.

"Loss of a Thumb and Index Finger of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.

"Loss of Use" means total paralysis of a limb or limbs which is determined by a competent medical authority to be permanent, complete, and irreversible with respect to: 1) arm, at or above the elbow joint; 2) leg, at or above the knee joint; 3) hand, at or above the wrist joint; and, 4) foot, at or above the ankle joint.

Exposure and Disappearance

If you or a covered family member experience a covered loss due to unavoidable exposure to the elements following a Covered Accident, we will pay the Principal Sum multiplied by the percentage applicable to that covered loss.

If you or a covered family member disappears and are not found within one year from the date of the wrecking, sinking, or disappearance of the conveyance in which he or she was riding during a trip that would otherwise be covered under the policy, it will be presumed that he or she died as a result of a Covered Accident.

Accidental Burn and Disfigurement Benefit

If you suffer burns that leave you disfigured, we will pay 10% of your Principal Sum, up to $20,000. The burns must result, directly and independently of all other causes, from a Covered Accident. The disfigurement must require reconstructive or cosmetic surgery to restore physical abilities or correct the disfigurement. The surgery must be commenced or performed within twelve months of the covered accident.

"Disfigurement" or **"disfigured"** means spoiled or deformed appearance caused by burns that can be corrected by means of reconstructive or cosmetic surgery.

Bereavement & Trauma Counseling Benefit

We will pay $100 per session for up to 10 counseling sessions, when you and/or an Immediate Family Member require bereavement and trauma counseling because you suffered a Covered Loss. Such counseling must meet all of the following conditions: 1) covered bereavement and trauma counseling expenses must be incurred within one year from the date of the Covered Accident causing the Covered Loss; 2) the expense is charged for a bereavement or trauma counseling session for you and/or one or more of your Immediate Family Members; 3) counseling is provided under the care, supervision or order of a Doctor; and 4) a charge would have been made if no insurance existed.

Covered bereavement and trauma counseling benefits do not include any expense for which you are entitled to benefits under any Workers' Compensation Act or similar law.

Carjacking Benefit

We will pay 10% of your Principal Sum, up to $25,000, if you suffer a covered loss from an injury resulting directly and independently of all other causes from an accident that occurs during a carjacking of an automobile you are operating, getting into or out of, or riding as a passenger. An official police report must provide verification of the carjacking within 24 hours of the carjacking or as soon as reasonably possible, or it must be certified by the investigating officer(s) within 24 hours of the carjacking or as soon as reasonably possible.

Child Care Center Benefit

If you die as a result of a covered accident, we will pay 3% of your principal sum, up to $3,000 per year, for the care of each of your surviving dependent children in a child care center. To receive this benefit, all of the following conditions must be met:

- Coverage for your dependent children was in force on the date of the Covered Accident that caused your death.
- One or more surviving dependent children is under age 13 and: a.) was enrolled in a child care center on the date of the Covered Accident; or b.) enrolls in a child care center within 90 days from the date of the Covered Accident.

At the end of each 12-month period following the date of your death, this benefit will be payable to your surviving spouse if he or she has custody of the child. If your spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. A claim must be submitted to us at the end of each 12-month period. Benefits will continue until age 13 for each child.

Coma Benefit

If you become comatose within 31 days of a Covered Accident and remain in a Coma for at least 31 days, we will pay a benefit of 1% of your Principal Sum for each month you remain in a coma up to the 11th month, and thereafter in a lump sum of 100% of your Principal Sum. The benefit payments will end on the earlier of; a) the end of the month in which you recover; b) the end of the month in which you die; or c) the end of the 11th month for which this benefit is payable.

Common Accident Benefit

If you and your insured spouse die as the direct result of a Common Accident and you are survived by one or more dependent children; your spouse's Principal Sum will be increased to 100% of your Principal Sum, up to a maximum of $500,000.

"Common Accident" means the same Covered Accident, or separate Covered Accidents occurring within the same 24-hour period.

Common Carrier Benefit

If you suffer a covered loss that results directly and independently of all other causes from a covered accident that occurs while riding as a fare-paying passenger in, getting into or out of, or being struck by a Common Carrier, we will pay 100% of your principal sum.

"Common Carrier" means a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers, or a

transport Aircraft operated by the Air Mobility Command of the United States of America or a similar air transport service of another country.

Continuation of Insurance Expense Benefit (COBRA)

If you die and are survived by an insured spouse or dependent child, they may elect to continue group medical and/or dental insurance provided by your employer, in which we will pay a benefit for the cost of premium. To receive this benefit, all of the following conditions must be met:

- your death results directly and independently of all other causes from a covered accident;
- you are survived by a spouse and/or dependent child who is covered under the policy on the date of your death;
- your spouse and/or dependent child is covered under a medical or dental plan sponsored by your employer at the time of your death;
- your spouse and/or dependent child notifies us of their election within 60 days of your death to continue their existing coverage under group insurance plans sponsored by your employer as permitted by state or federal continuation law.

This benefit will equal the premium required to continue medical or dental insurance as described above. We will pay this benefit annually at 3% of your principal sum, up to $3,000 for a maximum of 3 annual payments. The benefit will be paid at the end of the year during which medical and/or dental insurance is continued, and we must receive request for reimbursement and proof of premium paid during the year. Benefit payments will end at the earliest of the following dates:

- the date the surviving spouse or dependent child is no longer eligible to continue medical and/or dental insurance coverage;
- the date benefit payments equal the maximum benefit amount;
- the end of the maximum benefit period.

Elder Survivor Benefit

We will pay 3% of your principal sum, up to $7,500 for a maximum of 2 annual payments to a Surviving Elder Dependent if you die directly and independently of all other causes from a covered accident.

Benefit amounts will be divided equally among all Surviving Elder Dependents. Benefits for any Surviving Elder Dependent will be paid until that Surviving Elder Dependent's death or once the maximum number of annual payments has been reached.

"Surviving Elder Dependent" means a parent, parent-in-law, grandparent, grandparent-in-law, great-grandparent, great-grandparent-in-law (whether natural, step, or adoptive) of a Covered Person who, on the date of his or her death, is primarily dependent on the Covered Person for support and maintenance and is eligible to be claimed as a dependent for Federal and State income tax purposes.

Emergency Medical Benefit

We will pay up to $10,000 for emergency medical services if you suffer a medical emergency during the course of a covered trip and are traveling 100 miles or more from your place of permanent residence.

Covered expenses must be approved by us in advance and services must be rendered by our assistance provider. Expenses include those that are incurred for guarantee of payment to a medical provider, hospital, or treatment facility.

Emergency Medical Evacuation Benefit

We will pay up to $100,000 for emergency medical evacuation if you suffer a medical emergency during the course of a covered trip; require emergency medical evacuation; and are traveling 100 miles or more away from your place of permanent residence.

Covered expenses must be approved by us in advance and services must be rendered by our assistance provider. Expenses include charges for ambulance services required while transporting you to the appropriate treatment facility; a doctor's or specialist's travel expenses and the medical services provided on location, if a doctor must be dispatched to make an assessment as to whether transport or evacuation is necessary; expenses to return each minor dependent child if you are over age 18, are the only person traveling with the child, and require hospitalization due to a medical emergency; costs incurred to transport an immediate family member to join you during your medical evacuation to a different hospital, treatment facility, or your place of residence.

Felonious Assault and Violent Crime Benefit

If you suffer a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault while on business or the premises of your employer, we will pay 5% of your principal sum amount applicable to the covered loss. To receive this benefit, we must receive a police report for the felonious assault or violent crime, and the covered accident must occur during any of the following:

- actual or attempted robbery or holdup;
- actual or attempted kidnapping;
- any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the assault occurred.

Benefits are not payable for treatment of any injury sustained or covered loss incurred by the following:

- violent crime or felonious assault committed by the covered person;
- felonious assault or violent crime committed upon the covered person by a Family Member, Fellow Employee, or member of the Same Household.

"Family Member" means the Covered Person's parent, stepparent, spouse or former spouse, son, daughter, brother, sister, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild, and stepchild.

"Fellow Employee" means a person employed by the same Employer as the Covered Person or by an Employer that is an affiliated or subsidiary corporation. It shall also include any person who was so employed, but whose employment was terminated not more than 45 days prior to the date on which the defined violent crime/felonious assault was committed.

"Member of the Same Household" means a person who maintains residence at the same address as the Covered Person.

Home Alteration & Vehicle Modification Benefit

If you are injured as a direct result of a covered accident and require home alteration or vehicle modification within one year of the covered accident in order to maintain an independent lifestyle, we will pay 10% of your principal sum, up to $25,000. You must not have required the use of any adaptive devices, home, or vehicle adaptation prior to the date of the covered accident.

Increased Dependent Child Dismemberment Benefit

We will pay an additional benefit amount, up to $50,000, if an insured dependent child suffers a covered loss resulting directly and independently of all other causes from a covered accident for which accidental dismemberment benefits are payable. If your dependent child suffers more than one loss in a covered accident, we will pay only one benefit — the largest — for all losses resulting from the same accident.

Rehabilitation Benefit

We will pay 10% of your principal sum, up to $10,000, if you require rehabilitation within two years after sustaining a covered loss resulting directly and independently of all other causes from a Covered Accident. "Rehabilitation" means medical services, supplies, or treatment, or Hospital confinement (or part of a Hospital confinement) that are essential for physical rehabilitation due to your loss and to prepare you to return to work. Also, it must be performed under the care, supervision, or order of a doctor and meet generally accepted standards of medical practice.

Repatriation of Remains Benefit

We will pay up to $50,000 for the return of your remains to your home if your death is a direct result of a Medical Emergency while traveling 100 miles or more away from your permanent residence. "Covered Expenses" means costs pre-approved by us and incurred for any of the following: embalming, cremation, coffin or urn, transportation of the body or remains, or necessary travel expenses for an immediate family member or companion to join during the repatriation of your remains to your place of residence.

Seatbelt and Airbag Benefit

We will pay 10% of your principal sum, up to $25,000, if you suffer a Covered Loss directly and independently from Injuries sustained while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional 5% of your principal sum, up to $12,500, if you were also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag). Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with your claim to Us. If such certification or police report is not available or it is unclear whether you were wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, We will pay a default benefit of $1,000.

Special Education Benefit

We will pay 5% of your Principal Sum, up to $5,000, for each qualifying dependent child to enroll as a full-time student at a school of higher learning if you die as a direct result of a Covered Accident. To qualify, the dependent child must be enrolled as a full-time student in an accredited school of higher learning or be at the 12th grade level on the date of your Covered Accident and then enroll in an accredited school of higher learning within 365 days of the Covered Accident, continue his or her education as a full-time student in an accredited school of higher learning, and incur expenses payable directly to or approved by the school.

One payment will be made at the end of each year, up to four years, to each qualifying dependent child or to the child's legal guardian if the child is a minor. If no dependent child qualifies for this benefit within 365 days of your death, we will pay $1,000 to your beneficiary.

Spouse Retraining Benefit

We will pay 5% of your Principal Sum, up to $10,000, to enable your spouse to obtain occupational or educational training needed for employment if you die directly from a Covered Accident. In order to be eligible for this benefit, your spouse must have been insured under the policy on the date of your death.

The benefit will be payable only if you die within one year of a Covered Accident and your surviving spouse enrolls within one year after your death in any accredited school for the purpose of retraining skills required for employment and incurs expenses payable directly to or approved by the school.

Definitions

"Covered Accident" means an accident that occurs while your coverage is in force and results directly and independently of all other causes in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Person" means any eligible person including dependent(s) who applies for coverage and for whom the required premium is paid.

"Injury" means accidental bodily harm sustained by you that results directly and independently from all other causes from a Covered Accident. The Injury must be caused through accidental means. All Injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

What's Not Covered?

We will not pay benefits for any loss or Injury that is caused by, results from, or is contributed to by:

- Suicide or attempted suicide, intentionally self-inflicted injury.
- War or any act of war, whether declared or not.
- Service in the military, naval, or air service of any country or international organization.
- Sickness, disease, or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
- Piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
- Injury that occurs while the covered person is legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered under the advice and consent of a doctor.
- Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice.
- Commission of, or attempt to commit, a felony.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims.

Conversion Privilege

If your coverage ends for any reason other than the nonpayment of premium, you may apply for conversion insurance within 31 days after the date coverage under the policy ends. The conversion insurance will only contain Accidental Death and Dismemberment benefits.

Individuals eligible to convert their insurance may choose any type of accident insurance we have available in an amount not greater than the coverage in force under the policy, subject to the maximum amount available for conversion insurance.

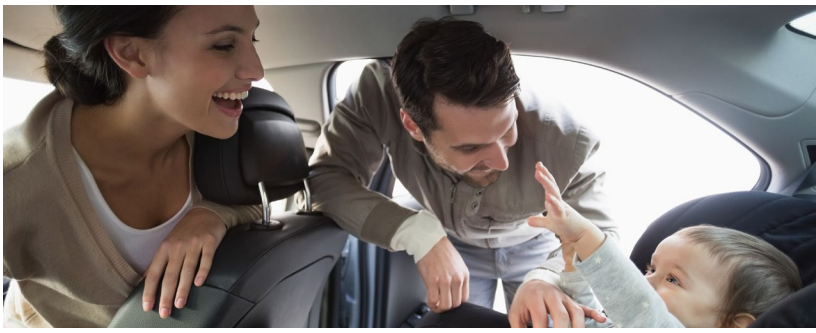
Premiums will be based on the table of rates in force at that time for such policies based on the individual's age and class of risk. No evidence of insurability is required.

Continuation of Insurance

Your dependents may continue insurance in the event of your death. To continue insurance your dependent must: 1) submit a written (or authorized electronic/telephonic) request for continued insurance within 31 days of your death; 2) meet all other eligibility requirements; and 3) pay the required premium.

This insurance will end on the first of the following dates to occur:
1) your dependent is no longer eligible, except for your death;
2) the end of the three-year maximum benefit period; or
3) the required premium is not paid.

Cost & Method of Payment



Employee Only

Select benefit amounts between $50,000 and $750,000 in increments of $50,000, not to exceed ten (10) times your annual salary. Your monthly cost of benefits is $0.025 for each $1,000 of Principal Sum you select.

Family Plan

If you elect the family plan, benefit amounts are determined based on the family members insured at the time of a covered accident. The Principal Sum for an insured spouse and insured dependent child are a percentage of your elected Principal Sum as shown here.

Your monthly cost of benefits is $0.046 for each $1,000 of Principal Sum you select.

Access to Chubb Travel Assistance, Worldwide

When an emergency happens far away from home, Chubb partners with AXA Assistance, a leading global travel and medical assistance provider, to give you access to local care and assistance - *wherever you are.*

If you are insured and need to access local care, AXA Assistance is available for timely help anywhere around the world by calling the telephone numbers on the ID Card.

To verify eligibility, call the multi-lingual call center 24 hours a day at:

- Within US or Canada: +1-855-327-1414 (toll-free)
- Outside US: +1-630-694-9764 (collect)
- Email: MedAssist-USA@AXA-Assistance.us

When calling AXA Assistance, please be prepared with the following:

- Name of caller or relationship to covered person
- Covered person's policy number
- Covered person's organization name
- Reason for calling

24/7 Assistance Services

In addition to the insurance protection provided by your insurance plan, you have access to your travel assistance services around the world. These services include, but are not limited to:

Medical Assistance

- Medical provider referrals
- Medical monitoring and treatment
- Guarantee of medical payment (GOP)
- Dispatch of physician
- Dispatch of prescription medication
- Emergency medical evacuations
- Medically necessary repatriation
- Transport of family member/ Escort of dependents
- Return of mortal remains
- Global Teleconsultation
- Remote Behavioral Health

Travel Assistance

- General travel information
- Pre-trip medical referral
- Emergency travel arrangements
- Lost/stolen personal item assistance
- ID theft assistance and advice
- Vehicle returns
- Emergency cash advance
- Translator or interpreter assistance
- Embassy and consular information
- Emergency message transmission
- Legal/bail bond referral

Security Assistance

- Access to 24/7 security assistance and safety advice
- On-the-ground crisis response for security, natural disaster, or political evacuation and repatriation

Travel Assistance Portal

- Access to real-time, destination-based health, security, and travel-related resources with self-service tools before or during travel excursions, including security alerts and country profiling
- Go to TravelAssistance.Chubb.com and register or log in
- Download the mobile app available for iOS or Android devices after registering to the travel portal via the desktop site

Scan the QR Codes

Scan the QR Codes below to save the following on your mobile device:

Starter Kit PDF

Save the Chubb Travel Assistance Program Starter Kit and add to your files on iOS or Android devices.

Add v-Contact Card

Customize and label contact details and note in "Policyholder Name" and "Policy Number" from the cutout portion of ID Card below.

This information provides you with a brief outline of the services available to you. These services are not insured benefits. Reimbursement for any service expenses is limited to the terms and conditions of the policy under which you are insured. You may be required to pay for services not covered. A third-party vendor may provide services to you. AXA Assistance makes every effort to refer you to appropriate medical and other service providers. It is not responsible for the quality or results of service provided by independent providers.

In all cases, the medical provider, facility, legal counsel, or other professional service provider suggested by AXA Assistance are not employees or agents of AXA Assistance and the choice of provider is yours alone. AXA Assistance assumes no liability for the services provided to you under this arrangement, nor is it liable for any negligence or other wrongful acts or omissions of any of the legal or health care professionals providing services to you. Travel assistance services are not available if your coverage under the policy is not in effect.

Your Travel Identification Card

Please cut out your identification card below and carry it with you at all times so you can be best served in case of an emergency.

CHUBB

For travel and medical assistance services, please call:

Chubb Travel Assistance
Inside US: +1-855-327-1414
Outside US: +1-630-694-9764
Email at: MedAssist-USA@AXA-Assistance.us

Travel Assistance Portal
Visit website: TravelAssistance.Chubb.com

CHUBB AXA

Policyholder: Chubb INA Holdings, Inc.
Policy Number: ADD N04156274

AXA Assistance provides emergency medical and travel assistance services and pre-trip information services. Call when you require:

- Hospital or doctor referral
- Emergency medical assistance; hospitalization
- Medically necessary evacuation or repatriation
- Guarantee of payment for medical expenses
- Translation or interpreter assistance
- Security/political event emergency support

This is not a medical insurance card.

CHUBB

Accidental Death Claim Form

IMPORTANT NOTICE: Written notice of claim must be provided within 90 days of the loss. Written proof of loss must be provided within 90 days after the date of loss. If it cannot be provided within that time period, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted more than one year from the date it was otherwise required.

Please mail your completed Claim Form along with the items listed below to:

Chubb USA
PO Box 5124
Scranton, PA 18505-0556

800.336.0627 Inside USA
302.476.6194 Outside USA
ChubbAandHClaims@Chubb.com

In addition to the Claim Form, the following items are required:

1. A Certified Copy of the final death certificate;
2. The company's enrollment benefit form and Beneficiary Designation;
3. Confirmation of employee's Principal Sum and current premium payment;
4. The Police Report, any Autopsy Report, and any newspaper clippings;
5. If Business Travel, a copy of the employee's itinerary prior to the accident, purpose of trip, destination to and from trip, and confirmation that trip was authorized by the company.

Policyholder Name: Policy Number(s):

Facts Concerning Insured

Full Name: SSN:

Home Address:

Date of Birth: Place of Birth:

Date of Death: Occupation:

Name of Employer:

Employer Address:

Beneficiary

Name: Date of Birth:

Relationship to Deceased: SSN:

Address: Phone:

Statements Regarding the Accident

Date of Accident: Place:

State specifically how accident happened:

Did the accident occur in the course or during the deceased's employment? ☐ Yes ☐ No

If yes, has there been, or will there be, a claim filed for Workers' Compensation? ☐ Yes ☐ No

Name of Workers' Compensation Carrier:

Address:

To Be Completed if Death Resulted from Motor Vehicle Accident

Type of Vehicle: Registered Owner:

Was the deceased the driver? ☐ Yes ☐ No

Use of vehicle: ☐ Business ☐ Pleasure ☐ Business and Pleasure

Name of law enforcement agency investigating accident:

Address:

To Be Completed on All Claims

Was an inquest held? ☐ Yes ☐ No

If yes, please complete the following and attach a copy of the proceedings and verdict

Name of person conducting autopsy: Title:

Address:

First Physician Attending Deceased After Injury

Name:

Address:

Previous Medical History

Was deceased treated for any medical conditions within five years prior to accident? ☐ Yes ☐ No

If yes, please list physician(s) in attendance below:

Name: Medical condition:

Dates of treatment:

Address:

Name: Medical condition:

Dates of treatment:

Address:

Name: Medical condition:

Dates of treatment:

Address:

By signing below I hereby certify that these statements and answers are true and correct to the best of my knowledge and belief.

Signature of beneficiary/claimant: Dated:

Address:

Authorization and Assignment of Benefits

I *authorize* any physician, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to _____ , deceased, to give us or our legal representative any and all such information for the purpose of evaluating a claim for benefits.

I *understand* the information obtained by use of this authorization will be used by ACE American Insurance Company or any of its affiliates to determine eligibility for benefits under the policy insuring said deceased. Any information obtained will not be released by us to any person or organization except to reinsuring companies, policyholders or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, permitted or as I may further authorize.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.

I *agree* this Authorization shall be valid for two years from the date shown below.

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 Insured or Authorized Representative, Beneficiary, or Next of Kin:

Dated:

Address:

Fraud Warning:
Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
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.

Florida
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York
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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.

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Accidental Dismemberment Claim Form

IMPORTANT NOTICE: Written notice of claim must be provided within 90 days of the loss. Written proof of loss must be provided within 90 days after the date of loss. If it cannot be provided within that time period, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted more than one year from the date it was otherwise required.

Please email your completed Claim Form along with the police/accident report, medical records, and witness statement to:

Chubb USA
PO Box 5124
Scranton, PA 18505-0556

800.336.0627 Inside USA
302.476.6194 Outside USA
ChubbAandHClaims@Chubb.com

Policyholder Name: Policy Number(s):

Insured Statement

Full Name: SSN:

Home Address:

Date of Birth: Place of Birth:

Employed by:

Occupation: Annual Salary:

Employer Address:

Describe Duties:

Accident Information

When did it happen? Where did it happen?

How did it happen?

What were you doing at the time?

What injury did you recieve?

When did you stop working?

Name and Addresses of All Physicians Consulted

Name: Date of Treatment:

Address:

Name: Date of Treatment:

Address:

Name: Date of Treatment:

Address:

What operation was performed?

If in a hospital, which one?

Name and Addresses of Witnesses to Your Accident

Name:

Address:

Name:

Address:

Name:

Address:

Employer's or Administrator's Statement

Group Policy No.: Certificate No. (if applicable):

Policyholder Name:

Occupation: Annual Salary:

Amount of Insurance: Insurance Effective Date:

Length of Employment — *From:* *To:* Date Cancelled (if applicable):

Address:

Date of Accident: Last Date at Work:

Signature of Official Representative: Dated:

Authorization and Assignment of Benefits

I *authorize* any physician, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to _____ to give us or our legal representative any and all such information for the purpose of evaluating a claim for benefits.

I *understand* the information obtained by use of this authorization will be used by ACE American Insurance Company or any of its affiliates to determine eligibility for benefits under the policy. Any information obtained will not be released by us to any person or organization except to reinsuring companies, policyholders or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, permitted or as I may further authorize.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.

I *agree* this Authorization shall be valid for two years from the date shown below.

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 Insured or Authorized Representative: Dated:

Address:

Attending Physician Statement

Patient's Name: Date of Birth:

Patient's Address:

Diagnosis:

If loss is sight, is loss in both eyes? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, visual acuity at this time:

If loss is hearing, is loss in both ears? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, hearing at this time:

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No

If no, speech at this time:

If loss is extremity, where is severance?

In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

In your opinion, was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, list dates you provided treatment for this illness:

Please give an account of the accident as you understand it happened:

Dates of treatment for this accident:

To your knowledge, has the patient ever been treated for this same condition? ☐ Yes ☐ No

If yes, please explain:

Remarks:

Name (Attending Physician): Phone No:

Address:

Signature of Insured or Authorized Rep: Dated:

Fraud Warning:
Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
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.

Florida
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York
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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland/Oregon
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 may be guilty of insurance fraud.

Virginia
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 may have violated state law.

Chubb. Insured.℠

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Emergency Medical Evacuation Claim Form

IMPORTANT NOTICE: *Written notice of claim must be provided within 90 days of the loss. Written proof of loss must be provided within 90 days after the date of loss. If it cannot be provided within that time period, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted more than one year from the date it was otherwise required.*

Please mail your completed Claim Form with itemized bills and receipts to:
(to expedite your claim, please email it with readable bills/receipts)

Chubb USA
PO Box 5124
Scranton, PA 18505-0556

(800) 336 0627 Inside USA
(302) 476 6194 Outside USA
ChubbAandHClaims@Chubb.com

Please complete Sections A, B, & C. Complete a separate Claim Form for each individual.

Section A. Patient Information

Employer: _____ Policy Number: ADD N04156274

Patient's Name: _____ Date of Birth: _____

Home Address: _____

Please provide telephone and facsimile numbers, with country and city codes.

Home #: _____ Work #: _____ Fax #: _____

E-mail: _____

Manager: _____ E-mail: _____

Work #: _____ Fax #: _____

Section B. Travel Information

Home country and country traveled to: _____

Left the above country on (DD/MM/YY): _____

Return date (DD/MM/YY): _____

The purpose of trip: _____

Section C. Payment Information
Please complete either Option 1 or Option 2

Option 1 - Payment to Employee's Representative

☐ Your home address ☐ Direct deposit to your bank account

Name on account: _____ Account #: _____

Bank Name: _____ Swift Code: _____

Bank Address: _____ Currency: _____

IBAN: _____

Name: _____

Address: _____

Option 2 - Payment to Employer

Employer's Name: _____

Employer's Address: _____

Supporting Documents
In order to consider benefits under Emergency Medical Evacuation, please provide the following information:

- Expense for the Emergency Medical Evacuation
- Medical supporting documentation that the evacuation was medically necessary and recommended by a physician.
- Medical notes while on broad medical flight by medical personal
- Medical documentation from receiving hospital.

All transportation arrangements must be made by the most direct and economical routs and conveyance possible and may not exceed the usual and customary charges for similar transportation in the locality where the expense is incurred. Benefits will not be payable unless We (or our authorized assistance provider) authorize in writing. Or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance company. Failure to follow these established rules will lead to a reduction or denial of benefits under this insurance coverage.

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. 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 as 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 Insured or Authorized Representative: _____

Relationship (if other than Insured): _____ Dated: _____

Address: _____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Patient's Signature:_____ Date _____

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
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.

Florida
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York
Any person who knowingly and with 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 thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania:

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland/Oregon

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 may be guilty of insurance fraud.

Virginia

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 may have violated state law.

CHUBB

Repatriation of Remains Claim Form

IMPORTANT NOTICE: *Written notice of claim must be provided within 90 days of the loss. Written proof of loss must be provided within 90 days after the date of loss. If it cannot be provided within that time period, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted more than one year from the date it was otherwise required.*

Please mail your completed Claim Form with itemized bills and receipts to:
(to expedite your claim, please email claim with readable receipts)

Chubb USA
PO Box 5124
Scranton, PA 18505-0556

(800) 336 0627 Inside USA
(302) 476 6194 Outside USA
ChubbAandHClaims@chubb.com

Please complete Sections A, B, & C. Complete a separate Claim Form for each individual.

Section A. Patient/Deceased Information

Employer: _____ Policy Number: _____

Patient's Name: _____ Date of Birth: _____

Home Address: _____

Please provide telephone and facsimile numbers, with country and city codes.

Home #: _____ Work #: _____ Fax #: _____

E-mail: _____

Manager: _____ E-mail: _____

Work #: _____ Fax #: _____

Section B. Travel Information

Home country and country traveled to: _____

Left the above country on (DD/MM/YY): _____

Return date (DD/MM/YY): _____

The purpose of trip: _____

Section C. Payment Information
Please complete either Option 1 or Option 2

Option 1 - Payment to Employee's Representative

☐ Your home address ☐ Direct deposit to your bank account

Name on account: _____ Account #: _____

Bank Name: _____ Swift Code: _____

Bank Address: _____ Currency: _____

IBAN: _____

Name: _____

Address: _____

Option 2 - Payment to Employer

Employer's Name: _____

Employer's Address: _____

Supporting Documents
In order to consider benefits under Repatriation of Remains please provide the following information:

- Expense for embalming or cremation
- The least costly coffin or receptacle adequate for transporting the remains
- Cost to transport the body from the place of loss to his/her home country
- Escort Services: expense for one (1) family member or companion who is traveling with the covered person to join the covered person's body during the repatriation to the covered person's place of residence

All transportation arrangements must be made by the most direct and economical routs and conveyance possible and may not exceed the usual and customary charges for similar transportation in the locality where the expense is incurred. Benefits will not be payable unless We (or our authorized assistance provider) authorize in writing. Or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance company. Failure to follow these established rules will lead to a reduction or denial of benefits under this insurance coverage.

CHUBB

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. 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 as 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 Insured or Authorized Representative: _____

Relationship (if other than Insured): _____ Dated: _____

Address: _____

Patient's Signature and Release (Parent or Guardian, if claim is for a minor), I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading, or incomplete information. I authorize the release of all records or other information which may be necessary to determine claim payment.

Patient's Signature:_____ Date _____

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalized fraud stated. We have adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications and enrollment forms.

District of Columbia Generic 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.

The following states have required us to use state specific language as follows:

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York - 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 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.

Oklahoma:WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes and claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Oregon: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Virginia: 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.