

Assurant Supplemental Coverage

ACCIDENT CLAIM FORM

Instructions:

Please complete all sections, sign and date, then mail or fax this form **with** the following information to the contact information at top right.

- Bills for treatment of this accident along with any accident reports
- Police report for automobile accidents
- Bills containing the diagnosis and procedure codes
- Emergency Room notes/discharge paperwork, if applicable
- Operative report for surgical claims, if applicable

SECTION 1: Claimant's Information			
Claimant's relationship to policy owner <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			
Last Name		First Name	
			MI
Address		City	State
			ZIP
Policy No.	Social Sec. No. (optional)	Phone Number (Day)	Phone Number (Night)

SECTION 2: Specific Accident Information	
Date of accident:	Date of initial medical treatment:
Was this a work related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the accident covered by Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the accident was a result of an automobile accident, was the claimant? <input type="checkbox"/> Driver <input type="checkbox"/> Passenger Please include a copy of the incident or police report, if applicable	
Please give the specific details of the accident including how the accident occurred, what transpired and when it occurred.	
Name and address of hospital facility where you sought treatment	
Name and address of doctor who treated you	

In order for your claim to be expedited, we need all the requested information at time of claim.

SECTION 3: Claimant Authorization and Signature

I hereby request and authorize you to furnish to Time Insurance Company or its representatives any and all medical information concerning any illness or injury I may have suffered. (Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same legal authority as the original.

Signature of Claimant (If minor, parent must sign)	Relationship to Claimant	Date
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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.
