

ACCIDENTAL DEATH CLAIM FORM

Seven Corners, 303 Congressional Blvd., Carmel, IN 46032 Phone: 877-444-5009 Fax: 317-575-2256;

Email: markel.memberclaims@sevencorners.com

PLEASE ANSWER ALL QUESTIONS TO AVOID DELAY IN PROCESSING THIS CLAIM

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF LOSS.

A. COVERED PERSON INFORMATION

Policy Name: <u>Kappa Alpha Order</u>		Policy Number: <u>4102AH256700-8</u>
Name of Insured: _____	Social Security: _____	Effective Date: _____
Home Address: _____		
Street Address	City	State Zip Code

B. BENEFICIARY INFORMATION

Name: _____	Relation to Student: _____	Date of Birth: ____/____/____	Social Security: _____
Home Address: _____			
Street Address	City	State Zip Code	Phone Number
Name: _____	Relation to Student: _____	Date of Birth: ____/____/____	Social Security: _____
Home Address: _____			
Street Address	City	State Zip Code	Phone Number

C. CLAIM INFORMATION

Nature of Injury: _____	Date of Injury: _____	Date of Death: _____
Please describe in detail the circumstances of accident (attach separate sheet if needed): _____		
Was the accident related to: Employment Yes <input type="checkbox"/> No <input type="checkbox"/> Automobile Accident Yes <input type="checkbox"/> No <input type="checkbox"/>		
If either response above is Yes, please explain: _____		
Please list the name and complete address of all treating physicians and hospitals: _____		

COPIES OF THE BENEFICIARY DESIGNATION, ANY POLICE REPORTS, A COPY OF THE AUTOPSY REPORT INCLUDING TOXICOLOGY RESULTS (IF APPLICABLE) AND A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS FORM.

HIPAA COMPLIANT AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Records and information obtained will be disclosed to the insurance company or their authorized Program Administrator. The purpose of this disclosure is to evaluate my application to activate benefits. I hereby authorize for you to release any and all records and information within your possession, custody and control pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my/their physical or mental condition are to be released. Such records and information to be released may include but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescription, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, record custodians, or anyone else to release any and all records and information regarding:

Patient's Name: _____
Other Names Used: _____
Date of Birth: ____/____/____
Social Security Number: _____

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the program administrator and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of (12) twelve months from my date of signature below. I understand I may revoke this Authorization at any time by requesting such of the Program Administrator in writing to: **303 Congressional Blvd., Carmel, IN 46032**, unless action has already been taken in reliance upon it. A photocopy of this Authorization will be treated in the same manner as the original.

Date: ____/____/____ **Signature of Patient/Guardian/Personal Representative:** _____

Legal relationship to applicant: _____
(Only if signed above by guardian or personal representative)

PLEASE NOTE:

In furnishing this or other claim forms for the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

FRAUD STATEMENTS

GENERAL: 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.

ALASKA: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

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. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

DISTRICT OF COLUMBIA RESIDENTS: 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.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: 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.

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

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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.

MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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, 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.

OHIO: 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 is guilty of insurance fraud.

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

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, may be violating state law.

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 act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: 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.

TEXAS: 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.

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.

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

