ZURICH AMERICAN INSURANCE COMPANY
PROOF OF CLAIM – ACCIDENT MEDICAL EXPENSE

ZURICH

Mail claims to:
Zurich American Insurance Company
P. O. BOX 968041
Schaumburg, IL 60196-8041
Toll Free Number: 877-287-4805
Toll Free Fax: 866-255-2962

PART A

Claim Number:	Policyholder:
Name of Member:	Relationship to Member:
Name of Claimant(if different)	Date of Birth
Mailing Address	Social Security No.
Name and Address of Attending Physician/Dentist	

Part B	Date of Accident	Place of Accident / Facility Name
	Diagnosis	Type of Sport (if applicable)
	Describe the Accident	
	What part of the body was injured?	Which Side? R L (if applicable)
	Have you ever injured this body part before? If so on what date and list all the doctors who treated you with their mailing addresses. Yes or No Please circle one.	

Part C

Name of Member	Social Security #	Relationship: Father ☐ Mother ☐ Guardian ☐ Other ☐	
Address (Number) Street (Lot or Apt. No.)	City	State	Zip Code
Area Code – Home Telephone Number	Area Code – Work Telephone & Extension		
Occupation of Father or Male Guardian	Place of Employment	Employer: Area Code – Phone Number	
Occupation of Mother or Female Guardian	Place of Employment	Employer: Area Code – Phone Number	
Do you have any other health and/or accident insurance plan (other than this plan)? Claimant: Yes ☐ No ☐ Father: Yes ☐ No ☐ Mother: Yes ☐ No ☐ Guardian: Yes ☐ No ☐			
Is the injured person covered by other health and/or accident insurance plan?			
Name of other health and/or accident insurance company	Address	Policy Number	

* **INCLUDE ITEMIZED BILLS FOR MEDICAL TREATMENT AND YOUR PRIMARY INSURANCE CARRIER(S) BENEFIT SUMMARIES**

(AUTHORIZATION MUST BE COMPLETED BY CLAIMANT, OR PARENT OR GUARDIAN IF CLAIMANT IS A MINOR)

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance or reinsuring company, or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of claimant and any other non-medical information of claimant to give ZURICH AMERIAN INSURANCE COMPANY or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of this Authorization will be used by ZURICH AMERICAN INSURANCE COMPANY to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by THE ZURICH AMERICAN INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request a copy of this Authorization. I AGREE that a photographic or photostatic copy of this Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for the duration of the claim.

Signature of Claimant, or Parent or Guardian if Claimant is a minor Date

ATTENDING PHYSICIAN'S STATEMENT

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name: _____ Date of Birth _____

1. Diagnosis (describe nature of injury) . _____

_____

_____

2. Is condition the result of ☐ Illness ☐ Accident What date did accident occur? _____

If injury, how do you understand accident occurred? _____

_____

_____

3. Has the patient had treatment for the same or related condition before? ☐ Yes ☐ No If yes, when and by whom?

_____

_____

4. On what date were you first consulted for this condition? _____

Give dates of treatment: Office: _____

5. If hospitalized, give name and address of hospital and dates of confinement:

_____

Name Address Dates - From/To

_____

Name Address Dates - From/To

6. If surgery performed, please describe: _____

_____

7. Prognosis: _____

I hereby authorize The Zurich American Life Insurance Company or its representative to inspect all x-ray pictures, clinical records and to obtain full information, including etiology and prognosis, or other data that may be in my possession or under my control, and to make copies of same or any portion thereof, pertaining to:

_____

(Name of Patient)

Signed _____

(Degree) (Social Security or Tax ID No.)

Date _____

Address _____

(City) (State) (ZipCode)