



**American Foreign  
Service Association**  
6408-4549

## Claim Form In Hospital Daily Benefit Insurance

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information or conceals for the purpose of misleading information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime.

**This form is for In-Hospital Benefits Only. Your claim will be subject to delay or return if these instructions are not followed.**

- To the Association Member:**
1. Complete the Association Member section of this form
  2. Have the reverse side of the form completed and signed by the Attending Physician
  3. Return the fully completed form and the itemized hospital bill to the Administrator who will submit the form to the assigned Claim Office.
- To the Administrator:**
1. Give the form to the Association Member for completion as indicated above.
  2. Complete Administrator's section.
  3. Submit completed form to the assigned Claim Office.

### TO BE COMPLETED BY THE ASSOCIATION MEMBER

Claimant's name (Last Name)	(First Name)	(Middle Initial)	Date of Birth	Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Address (Street)	(City)	(State)	(Zip Code)
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Occupation	Telephone ( )
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<b>Complete if Claim is for Dependent Child</b> <input type="checkbox"/> Full time student <input type="checkbox"/> Part time student	Name and Address of School
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Relationship to Association Member	Association Member's Name (Last Name)	(First Name)
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Date Member of Association	Effective Date of In-Hospital Daily Benefit Insurance Coverage	Dates of Hospital Confinement From: To:
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Occurrence of Illness or Injury Date: Time:	Name and Address of Hospital
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If Injured, describe fully how and where accident occurred.

Please list any hospitals, clinics, or physicians that treated the hospitalized person during the past 2 years:			
Name	Complete Address	Phone Number	Treatment Period

I certify that the foregoing information is true and correct:

Signature of Association Member:	Date Signed
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I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to any Chubb Company, the Plan, Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

Name of Hospitalized Person	Signature of Hospitalized Person (Parent or Guardian in the event of minority or incapacity)	Date Signed
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### ADMINISTRATOR'S CERTIFICATION

Name of Employer/Association	Division
Address (Street)	(City) (State) (Zip Code) (Phone Number)

I certify that the foregoing information is true and correct	Signature of Authorized Representative	Date Signed
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**PHYSICIAN'S CERTIFICATE**

Patient's Name

Diagnosis and Concurrent Conditions (If Fracture or Dislocation describe nature and location)

When did symptoms first appear or accident happen?

When did patient first consult you for the condition? If referred to you, please provide name, address, and phone number of referring physician.

Has patient ever had same or similar condition? If yes, state when and degree

yes  no

Nature of Surgical Procedure, if any (describe fully)

In-Patient  Out-Patient Date Performed:

Remarks

Print Physician's Name

Degree

Tax I.D. Number

Address (Street)

(City)

(State or Province)

(Zip Code)

(Telephone Number)

Physician's Signature

Date Signed