



Arch Insurance Canada Ltd.
Accidental Death & Dismemberment
Claim Form

Claims Department: Executive Plaza IV, 11350 McCormick Road, Suite 102, Hunt Valley, MD 21031
Phone No: 1-844-800-2486 | **Fax:** 1-443-279-2901 | **Email:** redsky@archinsurance.com

Accidental Death & Dismemberment Claim Instructions

The Claimant/ Insured should complete and sign the Accidental Death & Dismemberment Insurance claim form in full and return it with the documentation noted below.

For all claims, submit:

- Copies of the insured's travel documents confirming the travel dates and itinerary;
- A copy of the accident report;
- A copy of the police report of the accident;
- A final, certified copy of the insured's death certificate;
- A copy of the autopsy report, if performed;
- A copy of the inquest report, if held;
- Medical records of the injury and treatment;
- Newspaper or other articles containing details of the accident;
- Any other information or documentation that would help to explain the circumstances of the insured's accident and death

Your claim should be submitted to the address at the top of these instructions.



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To be Completed by Beneficiary Claiming Benefits

Name of Claimant/Insured		Policy No.	
Address		Male <input type="checkbox"/>	Female <input type="checkbox"/>
		Date of Birth	
Travelling Companion(s)		Relationship	Trip Departure Date
			Trip Return Date
			Initial Trip Deposit Date
			Date of Death
Name of Beneficiary		Phone No. ()	
Address of Beneficiary		Male <input type="checkbox"/>	Female <input type="checkbox"/>
		Date of Birth	
Relationship of Beneficiary to Insured		Email Address	
Describe how accident occurred:			
Date and time of accident		Facility where the insured was treated after the accident	
Male <input type="checkbox"/> Female <input type="checkbox"/>			
Did death occur as the result of a motor vehicle accident?			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
Location of Accident			
Street			
City			
Province		Country	
Name of person driving the vehicle at the time of the accident			
Witness/Passenger Information (name, address, phone number)			
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Other Drivers Involved (name, address, phone number) 	
Other Drivers Involved (name, address, phone number) 	
Name of law enforcement agency investigating the accident	Phone No. ()
Was anyone cited by the police? Yes <input type="checkbox"/> No <input type="checkbox"/>	Please explain:
Was an inquest held? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of court holding hearing:	
Was an autopsy performed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please submit a copy of the report.	

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable by law

I have read the foregoing, and the above answers are true and complete according to the best of my knowledge and belief.

Signature of Claimant

Date