Accidental Death Claim Form

Claims Department:
Red Sky Claims, C/O Arch Insurance Company | Executive Plaza IV | 11350 McCormick Road, Suite 102 | Hunt Valley, MD 21031 USA
Toll Free Phone: (844) 800-2486 | **Fax:** (443) 279-2901 | **E-mail:** redsky@archinsurance.com
Any person who knowingly presents a false or fraudulent claim for payment of 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.

Accidental Death Claim Instructions

The Claimant/ Insured should complete and sign the Accidental Death 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.		Social Security Number
Address			Male ☐ Female ☐ Date of Birth
Traveling Companion(s)	Relationship	Trip Departure Date	Trip Return Date
		Initial Trip Deposit Date	
		Date of Death	
Name of Beneficiary	Phone No. ( )		Social Security Number
Address of Beneficiary			Male ☐ Female ☐ Date of Birth
Relationship of Beneficiary to Insured	Email Address		

Describe how accident occurred:

Date and time of accident AM ☐ PM ☐

Facility where the insured was treated after the accident:

Did death occur as the result of a motor vehicle accident? Yes ☐ No ☐

Location of Accident

Street

City

State Country

Name of person driving the vehicle at the time of the accident:

Witness/Passenger Information

Name

Address

Phone No. ( )

Witness/Passenger Information

Name

Address

Phone No. ( )

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Other Drivers Involved

Name _____

Address _____

Phone No. ( )

Other Drivers Involved

Name _____

Address _____

Phone No. ( )

Name of law enforcement agency investigating the accident	Phone No. ( )

Was anyone cited by the police?	Yes ☐	No ☐	Please explain:
Was an inquest held?	Yes ☐	No ☐	
Name of court holding hearing:			
Was an autopsy performed?	Yes ☐	No ☐	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 Beneficiary/Claimant **Date**

Authorization to Disclose Information

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Arch insurance Company, or it's authorized representative. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past.

To any insurance company, any travel organization or agency, airline carrier, cruise line, tour operator, rental agency, hotel, motel, or similar entity providing lodging on a rental / lease basis or any other person who may have knowledge regarding this claim: I authorize the release any information requested regarding this claim and the loss reported.

The company will use this information to determine if any claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigation or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effect and valid as the original and shall remain in effect for one year from the date of authorization.

I certify that the information given by me in support of my claim is true and correct. I understand that any person who knowingly and with intent to defraud or deceive any insurance company, files a claim containing any materially false, incomplete or misleading information may be subject to prosecution or insurance fraud.

_____ _____

Beneficiary or Authorized Representative's Signature **Date**

_____

If Authorized Representative, Relationship to Beneficiary

_____

or Legal Designation