Accident Insurance Claim Form

Please read and sign the declaration at the end of this claim form before sending your completed form to us. Failure to do so will result in your claim form being returned to you.

Insurance coverage is underwritten by StarNet Insurance Company, (domiciled in Iowa - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.

Program administered by Buddy Technology Inc. Claims administered by Crawford & Company.

CLAIMANT DETAILS

Policy Number_____ Coverage Start Date and Time _____ AM/PM(circle one) Coverage End Date and Time_____ AM/PM (circle one)

Policyholder Name_____

Policyholder Address_____

_____ Zip Code _____

Policyholder Date of Birth _____ Policyholder Phone Number _____

Policyholder Email Address _____

Injured Person's Social Security Number_____

*Injured person's social security number must be provided, as required by the Center for Medicare Services.

CLAIM DETAILS

Date of Accident_____ Time of Accident_____ AM/PM (circle one)

Where did the accident occur?

_____

_____

How did the accident occur? _____

_____

_____

What injuries did you sustain? _____

_____

_____

Did anyone witness the accident? ☐ YES ☐ NO

If yes please provide the full name(s) _____

Witness 1 Phone Number_____ Witness 1 Email Address _____

Witness 2 Phone Number_____ Witness 2 Email Address _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In order to process a claim for benefits, I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any kind, and all such information is to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, or its authorized Administrators or their legal representatives A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim (applicable to CA, CT, GA, HI, MA, MN, NC, NJ, OH and VA). For WI, this authorization shall be considered valid for the duration of the claim or policy term, whichever is longer. For all other states, this authorization is valid for 24 months from the date signed. I understand I, or my authorized representative, have a right to receive a copy of this authorization.

DECLARATION: I understand that making a fraudulent claim or knowingly exaggerated claim or providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this is, to the best of my knowledge and belief, true in every respect.

Full name of Insured Person_____

Date of Birth_____ Address_____

_____

_____ Zip Code_____

Attending Physician_____

Address_____

_____ Zip Code_____

Signature of Insured Person or Authorized Representative _____

Printed Name of Insured Person or Authorized Representative _____

Statement of Claim for
Accidental Dismemberment Benefits and Additional Benefits

Name of Insured _____

Attending Physician's Statement (to be completed by the attending physician)

1.Name of patient (First, Middle, Last)	Age	2.Date of accident causing present loss (Month, Day, Year)
3.Date first consulted on account of the injury described (Month, Day, Year)	4.Date of last treatment for this condition (Month, Day, Year)	

5. Describe the exact nature, location, and extent of all injuries sustained _____

_____

_____

6. Was the injury described solely responsible for the loss? ☐ Yes ☐ No
If not, give the particular of any contributing cause or causes. _____

_____

_____

7. Where is the patient being treated? Urgent Care/ Hospital Emergency Room

8. If the patient was admitted to hospital as a result of this injury please provide:
Date & time of admission_____ Date & time of discharge_____

Please also complete the applicable section for the benefit being claimed.

To be Completed Only For Limb/Digit Amputations

What limb/digit was severed or amputated?

_____

State the dates on which the severance or amputation occurred.

_____

_____

State the cause of the amputation.

_____

_____

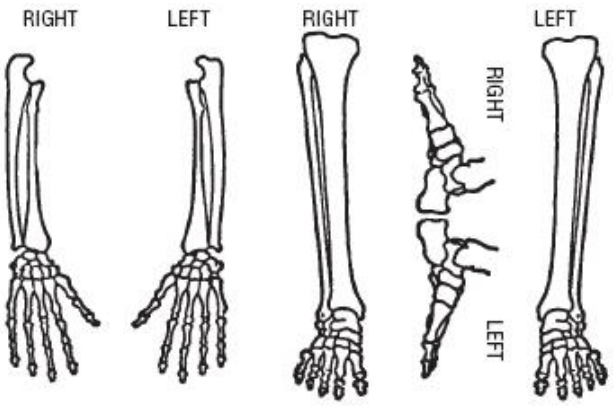
_____

If the limb/digit was reattached, indicate date of reattachment and functional outcome.

_____

_____

State the exact point at which the amputation was performed or the severance occurred with respect to each limb/digit lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.



_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Attending Physician (Required)

Date Signed (Month, Day, Year)

Print Name of Attending Physician

Name of Facility

Address

(_____) _____
Phone Number

Name of Insured _____

To be Completed Only For Loss of Vision

Has the patient had entire and irrecoverable loss of sight following the injury?

☐ Yes ☐ No

If yes, please answer the following:

Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

Date _____

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

Give the date and vision found on last eye examination.

Date _____

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

State the cause of loss of vision:

_____

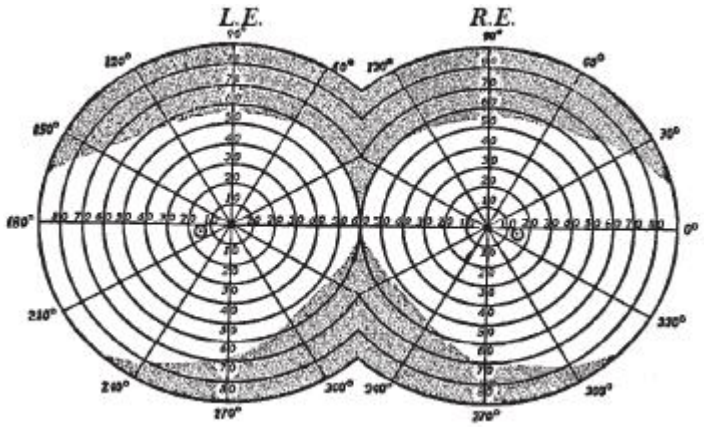
_____

_____

Indicate whether recovery or useful vision is possible by operation or treatment.

O.D.	☐ Operation	☐ Treatment
O.S.	☐ Operation	☐ Treatment

If fields of vision are contracted, show contraction on chart below.



To be Completed Only For Burn

Has the patient suffered third degree burns as a result of an accident? ☐ Yes ☐ No

What percentage of the body surface suffered third degree burns?

_____%

Location of third degree burns.

_____

_____

_____

_____

To be Completed Only For Rehabilitative Physical Therapy

Did the patient suffer a loss resulting from an accidental injury? ☐ Yes ☐ No

Date of accidental injury: _____

Did you prescribe rehabilitative physical therapy for the patient as a consequence of the loss? ☐ Yes ☐ No

Date therapy prescribed: _____

_____ _____

Signature of Attending Physician (Required) Date Signed (Month, Day, Year)

_____ _____

Print Name of Attending Physician Name of Facility

_____ (_____) – _____

Address Phone Number

Name of Insured _____

To be Completed Only For Paralysis

Date you first determined paralysis was permanent, complete and irreversible, etiology of the paralysis, and method of correction and result.

a) Date _____

b) Etiology _____

Specific limb(s) paralyzed _____

Location of lesion(s) responsible _____

Type of lesion(s) responsible _____

Test results which document paralysis (i.e., physical exam, EMG, nerve conduction tests) _____

Method of correction

Functional result of correction _____

To be Completed Only For Loss of Speech

State duration in months of patient's entire and irrecoverable loss of speech following the injury. _____

Date you first determined speech was irrecoverably lost and the specific etiology for absence of speech (vocalization) and method and results of correction.

a) Date _____

b) Specify basis for speech loss:

	Description Uncorrected	Corrected Method
Absence of vocalization structure(s)		
Evidence of obstruction		
Evidence of air passage defect		

To be Completed Only For Loss of Hearing

State duration, in months, of patient's entire and irrecoverable loss of hearing following the injury? _____

Date you first determined hearing was irrecoverably lost and the residual hearing (dB) uncorrected and corrected as tested by audiometer in a soundproof room.

a) Date _____

b) Audiometry:

	Left Ear Uncorrected / Corrected	Right Ear Uncorrected / Corrected
500 Hz	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

Date the test results which allowed you to determine the hearing loss lasted consecutively for the duration indicated above.

a) Date _____

b) Audiometry:

	Left Ear Uncorrected / Corrected	Right Ear Uncorrected / Corrected
500 Hz	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

To Be Completed Only For Wheelchair Access Modification

Did the patient suffer a loss resulting from an accidental injury? ☐ Yes ☐ No

Date of accidental injury: _____

Does the patient now require permanent use of a wheelchair for mobility? ☐ Yes ☐ No

Is the wheelchair requirement the direct and sole cause of the accidental injury? ☐ Yes ☐ No

_____ _____

Signature of Attending Physician (Required) | Date Signed (Month, Day, Year)

_____ _____

Print Name of Attending Physician | Name of Facility

_____ ( ) –

Address | Phone Number

Name of Insured _____

To be Completed Only For Brain Damage	To be Completed Only For Coma
Has the patient suffered permanent and irreversible physical damage to the brain as a result of an accidental injury, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life? ☐ Yes ☐ No Glasgow Coma Score _____ Date and cause of accidental injury: _____ Date brain damage manifested itself: _____ Was the patient hospitalized as a result of the accidental injury? ☐ Yes ☐ No Dates of hospitalization: _____ _____ State duration brain damage persisted after the injury: _____ _____	Did the patient enter into a state of deep and total unconsciousness from which he/she cannot be aroused as a result of an accidental injury? ☐ Yes ☐ No Glasgow Coma Score: _____ Date and cause of accidental injury: _____ _____ Date coma began: _____ Is the patient still in a coma? ☐ Yes ☐ No If the patient is not in a coma now, date coma ended: _____

To Be Completed Only For Exposure

Was the patient involved in an accident that resulted in loss of life or limb due to unavoidable exposure to the elements?
☐ Yes ☐ No

If loss of life, please explain how the exposure resulted in death.

_____
_____
_____

If loss of limb, which limbs were lost?

_____
_____
_____

State the dates on which amputations occurred.

_____
_____
_____

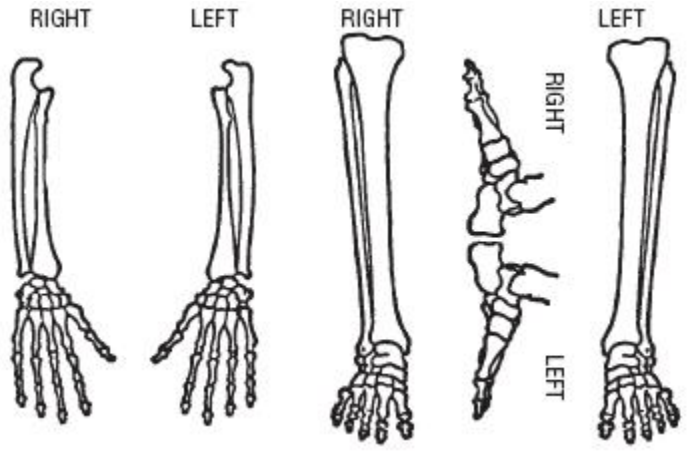
State the cause of the amputation.

_____
_____
_____

If the limb was reattached, indicate date of reattachment and functional outcome.

_____
_____

State the exact point at which the amputation was performed with respect to each limb lost. If the amputation was below the elbow or knee indicate on the chart the exact point of severance. _____
_____
_____
_____



_____ _____
Signature of Attending Physician (Required) Date Signed (Month, Day, Year)

_____ _____
Print Name of Attending Physician Name of Facility

_____ ( ) –
Address Phone Number

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DATA PROTECTION

Please note that your personal information may be used for the purposes of insurance administration and claims handling by us, Underwriters, it's associated companies, their co-insurers, the insured and their broker and other third parties advising us/Underwriters or otherwise relevant to the handling of your claim. Your personal information may be used by Underwriters and their reinsurer(s) and reinsurance broker(s) for any reinsurance claim made by them, for renewal purposes and for Underwriters management reporting and for internal and external audits.

Fraud Warning: 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. (Fraud language varies by state. **For New York Residents:** 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. For other state specific fraud warning notices, please see below.)

Signature of Insured Person or Authorized Representative _____

Printed Name of Insured Person or Authorized Representative _____

Date _____

*Notice to California Residents – Please refer to the attached Notice of Personal Information Collected pursuant to California Consumer Privacy Act (CCPA).

FRAUD WARNINGS

For residents of California: For your protection California law requires the following to appear on this form: a) Any person who knowingly present 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. b) A false statement in an application shall not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.

For residents of 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.

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FRAUD WARNINGS CONTINUED

For residents of 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.

For residents of Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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

For residents of Maine, Tennessee, Virginia and Washington: 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.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of 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.

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

CLAIM SUBMISSION

Please return your scanned, completed and signed claim form and all required documents to: iambuddy@us.crawco.com.

Crawford & Company
1605 N. Cedar Crest Blvd, Suite 407
Allentown, PA 18104

If you choose to mail your documents, please send a copy of your documents and retain the originals for your records. Crawford is unable to return any submitted documents. Upon receipt, your claim will be thoroughly reviewed. It may be necessary for Crawford to request additional information before a final determination is made.

Should you require any assistance in the completion of this form, please do not hesitate to contact Crawford by telephone at 1-866-641-7922.

Should you have any questions concerning your submitted claim, please do not hesitate to contact Crawford at:

New Losses (Crawford ClaimsAlert 24/7): 1-877-346-0300
Inquiries (Business Hours 8:30am-5pm Eastern Standard Time): 1-866-641-7922

W. R. Berkley Corporation
Notice of Personal Information Collected
(Pursuant to the California Consumer Privacy Act (CCPA))

This notice applies only to information received and collected by W. R. Berkley Corporation ("Berkley") from residents of the state of California.

In this notice, when we refer to "we", "us" or "our", it means one or more operating units of W. R. Berkley Corporation ("Berkley operating units").

When we refer to "you" and "your" in this notice, we mean a resident of the state of California whose personal information we may collect. More information about W. R. Berkley Corporation operating unit subsidiaries can be found on https://www.berkley.com/our-business/operating-units.

Below is a table showing the categories of personal information that one or more of the Berkley operating units collect in the course of performing insurance services and how it is used, Not every Berkley operating unit collects every category of personal information or uses it in all the ways listed below.

Personal Information Category	How it is Used
Identifiers (such as name, address, social security #, driver's license #, etc.) **Other Sensitive Information under California Law** *(Examples: physical description, financial information, medical information, etc.)* **Characteristics of protected classifications under California or federal law** *(Examples: race, sex, color, religion, national origin, marital status, etc.)* **Biometric information** *(Examples: fingerprints, keystroke patterns, gait patterns, sleep/health data, etc.)* **Geolocation Data** *(Information to identify physical location)* **Audio, electronic, visual, thermal, olfactory, or similar information.** *(Examples: audio and video recordings)* **Professional or employment-related information.** *(Example: job history)* **Education information** (information not publicly available as defined under federal law)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

Commercial information *(Examples: records of personal property, products, and services purchased or obtained, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; security; prevent fraud and improper use; internal research; collections; comply with laws and regulations.
Internet or other electronic network activity information *(Examples: browsing/search history, visitor's interaction with a website, etc.)*	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.
Inferences drawn from any of the other categories of information. (use of any of the above categories to create a profile about a consumer)	To perform insurance services for policyholders/ beneficiaries/claimants; maintain and improve quality of services; security; prevent fraud and improper use; internal research; identify and repair errors; comply with laws and regulations.

NEED MORE INFORMATION?

For additional information about how we collect, use, and share personal information, about California consumers' rights under the CCPA, and to make a consumer request, please see our online Privacy Policy at: https://www.berkley.com/privacy

This notice was updated on December 30, 2019