



For All the Commitments You Make®

PLEASE PRINT—USE A SEPARATE SHEET OF PAPER WHERE SPACE DOES NOT PERMIT.

Policy No. _____ of _____ (Name of Insured in full) (Address)

Date and place of deceased's birth. _____ City _____ State _____ Day _____ Month _____ Year

What was deceased's business or occupation at time of accident? _____

Deceased's average monthly earnings? _____ (If more than one, state all, and describe duties fully) Employer? _____ (Name and Address)

On what date did accident happen? _____ Day _____ Month _____ Year _____ Hour

How did the accident happen? _____ (Describe fully)

Where did it happen? _____ (If city or town, state street and number)

What was the deceased doing at the time of accident? _____ (Describe fully)

State names and addresses of all eye witnesses to accident. _____

Name and address of law enforcement agency involved: (Please submit copy of Police Accident Record) _____

Describe fully injuries received. _____

Names and addresses of all doctors who treated deceased between date of accident and date of death. _____

How long after this accident did deceased continue at work? _____, If deceased worked again prior to death, between what dates? From _____ To _____

Date of death? _____ Day _____ Month _____ Year _____ Place of death? _____ Hour

Was inquest held? _____ If so, attach hereto certified copy of verdict.

Was autopsy held? _____ If so, by whom? _____

Did deceased have any chronic disease or physical defect or deformity? _____ If so, what? _____

What other accidental death or life insurance did deceased have? _____ (State names of companies and amount in each)

Claimant's name _____, of _____ Address _____ City _____ State

Your age _____ In what capacity are you making claim? _____ (State whether beneficiary, executor, administrator, guardian, trustee or assignee)

NOTE: If other than beneficiary, attach appropriate legal documents substantiating your authority.

Your relationship to insured _____ What amount of indemnity are you claiming? \$ _____

I authorize any physician, hospital, or other medically related facility, insurance company or other organization, institution or person, that has any records, or knowledge of the insured or his/her health to disclose whenever requested to do so by CNA or its representative, any and all such information. A Photostatic copy of this authorization shall be considered as effective and valid as the original.

I know it is a crime for any person to intentionally attempt to defraud or knowingly facilitate a fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement(s).

Claimant's Signature _____ Date _____