STARR INDEMNITY & LIABILITY

ACCIDENTAL DEATH CLAIM FORM

Federal Employees Accident Insurance Program

Individual Policyholder:
Policy Number:

In addition to the claim form, the following items are required:
(1) A Certified Copy of the final death certificate;
(2) Your company's enrollment benefits form and Beneficiary Designation;
(3) Confirmation of employee's Principal Sum and current premium payment;
(4) The Police Report, any Autopsy Report, and any newspaper clippings.
(5) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of trip, destination to and from trip, and confirmation that trip was authorized by the company.

Insured	**Certificate Number(s)**

Facts concerning insured

Full Name	Social Security Number
Address	

Date of Birth	Place of Birth	Date of Death

Occupation	Name of Employer
Employer's Address	

Beneficiary

Name	Relationship to Deceased	Date of Birth	Social Security Number
Address			Telephone: ( )

Statements Regarding the Accident

Date of Accident	Place

State Specifically how Accident Happened

Did the accident occur in the course or during deceased's employment?
☐ Yes ☐ No If "yes", has there been, or will there be, a claim filed for Worker's Compensation? ☐ Yes ☐ No

Name of Worker's Compensation Carrier

Address

To be completed if death resulted from motor vehicle accident

Type of Vehicle	Registered Owner	Was deceased the driver?

Use of vehicle: ☐ Business ☐ Pleasure ☐ Business and Pleasure

Name of law enforcement agency investigating accident

Address

To be completed on all claims

Was an inquest held? ☐ Yes ☐ No If "yes", complete the following and attach a copy of proceedings and verdict.

Name of court holding hearing

Address

Was an autopsy conducted? ☐ Yes ☐ No If "yes", complete the following and attach certified copy of report.

Name of person conducting autopsy	Title
Address	

First physician attending deceased after injury

Name:	Address:

Previous medical history

Was deceased treated for any medical conditions within five years prior to the accident?

☐ Yes ☐ No If "yes", list physician(s) in attendance below

1	Name	Address
	Medical Condition	Dates of treatment
2	Name	Address
	Medical Condition	Dates of treatment
3	Name	Address
	Medical Condition	Dates of treatment

Other insurance on life of deceased

Company name	Address	Amount
Company name	Address	Amount
Company name	Address	Amount
Company name	Address	Amount

By signing below I hereby certify that these statements and answers are true and correct to the best of my knowledge and belief.

Signature of beneficiary/claimant	Dated
Address	

I *authorize* any physician, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to _____, deceased, to give Starr Indemnity & Liability Company or its legal representative any and all such information for the purpose of evaluating a claim for benefits.

I *understand* the information obtained by use of this authorization will be used by Starr Indemnity & Liability Company to determine eligibility for benefits under the policy insuring said deceased. Any information obtained will not be released by Starr Indemnity & Liability Company to any person or organization except to reinsuring companies, policyholders or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, permitted or as I may further authorize.

I *agree* that a photographic copy of this Authorization shall be a valid as the original.
I *agree* this Authorization shall be valid for two years from the date shown below.
I understand that I or my authorized representative may request a copy of this authorization.
I understand that I or my authorized representative may revoke this authorization at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured, Authorized Representative, Beneficiary or Next of Kin:	Dated
Address:	

PLEASE MAIL COMPLETED FORM TO:

Starr Indemnity & Liability Claims Department
1601 Market Street, Suite 1800
Philadelphia, PA 19103