Mail claims to:
Zurich American Insurance Company
P. O. BOX 968041
Schaumburg, IL 60196-8041
877-287-4805

ZURICH

MCM PROOF OF DEATH CLAIM FORM

☐ PERSONAL INSURANCE ☐ GROUP INSURANCE PART I (TO BE COMPLETED BY THE MEMBER/BENEFICIARY)

NAME OF DECEASED:	DATE OF BIRTH:	POLICY /CERTIFICATE NO.:
ADDRESS OF DECEASED:	POLICY ISSUED TO:	OCCUPATION OF DECEASED:

DATE OF ACCIDENT: (MONTH) (DAY) (YEAR) | HOUR: A.M. P.M.

WHERE DID THE ACCIDENT HAPPEN:

HOW DID THE ACCIDENT HAPPEN:

WHAT WAS THE DECEASED DOING AT THE TIME OF THE ACCIDENT:

WHAT INJURIES WERE RECEIVED:

STATE NAMES AND ADDRESSES OF ALL EYEWITNESSES TO ACCIDENT:

NAME OF HOSPITAL: | STAY IN HOSPITAL: FROM: TO:

NAME AND ADDRESS OF DOCTORS ATTENDING THE DECEASED FOLLOWING THE ACCIDENT:

DOCTOR: ______ ADDRESS: ______
DOCTOR: ______ ADDRESS: ______
DOCTOR: ______ ADDRESS: ______
DOCTOR: ______ ADDRESS: ______

WAS THIS ACCIDENT REPORTED TO THE POLICE DEPARTMENT: YES NO IF YES, PLEASE INDICATE POLICE DEPT. NAME:

WAS INQUEST HELD? ☐ YES ☐ NO IF YES, PLEASE ATTACH CERTIFIED COPY OF VERDICT

WAS AUTOPSY HELD? ☐ YES ☐ NO IF SO, WHO CONDUCTED THE AUTOPSY (NAME AND ADDRESS)

WHAT WAS THE DECEASED'S BUSINESS OR OCCUPATION AT THE TIME OF THE ACCIDENT?

EMPLOYER?

DID DECEASED HAVE ANY CHRONIC DISEASE, PHYSICAL DEFECTS OR DEFORMITIES? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

LIST OTHER APPLICABLE HEALTH, ACCIDENT, OR LIFE INSURANCE:
COMPANY: ______ POLICY NO.: ______ PRINCIPAL SUM: ______
COMPANY: ______ POLICY NO.: ______ PRINCIPAL SUM: ______
COMPANY: ______ POLICY NO.: ______ PRINCIPAL SUM: ______

WHAT AMOUNT ARE YOU CLAIMING: | DO YOU CLAIM AS: ☐ BENEFICIARY ☐ ADMINISTRATOR ☐ EXECUTOR

DATE OF BIRTH OF BENEFICIARY:

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PERSON TO FURNISH ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS OR INJURY, MEDICAL HISTORY, CONSULTATION, PRESCRIPTIONS, OR TREATMENT, AND COPIES OF ALL HOSPITAL OR MEDICAL RECORDS REGARDING ___________________________________ DECEASED. I HEREBY AUTHORIZE ZURICH NA INSURANCE COMPANY OR ITS REPRESENTATIVE TO RELEASE THE INFORMATION DESCRIBED ABOVE TO ANY EXPERT, INVESTIGATOR, PHYSICIAN, MEDICAL PRACTICIONER, HOSPITAL, MEDICAL OR MEDICAL RELATED FACILITY, INSURANCE COMPANY, REINSURER, PLAN ADMINISTRATOR, PLAN SPONSOR OR EMPLOYER FOR THE PURPOSE OF INVESTIGATING AND/OR ADJUDICATING MY CLAIM. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.	
SIGNATURE:	DATE:
ADDRESS:	
WITNESS:	DATE:
ADDRESS:	

STATEMENT OF ATTENDING PHYSICIAN

In relation to the death of _______________________________________, of ____
(name) (address)

1. How long has the Insured been your patient?

2. Please give the names of other physicians who have attended this patient, and the dates of their first and last treatments as reported to you

   Names:____ Dates of Treatment:____
   ____
   ____
   ____

3. Date of Death __________________________Month___________________Day___________________Year_______________Hour___________________

4. What was the primary cause of death?____ natural causes_________, or accident _________

5. Date of accident ________________________Month__________________Day____________________Year______________Hour_____________________

6. On what date did you first attend deceased for the above condition? Month______________ Day_________________Year________________________

7. Describe his/her condition at that time? ____

8. Between what dates did you treat deceased? From________________________To____

9. How did the accident occur? ____

10. What was the precise nature and extent of injuries? (Describe fully all visible evidence)____

11. What was the secondary or contributory cause of death?____

12. Did any disease cause, other than the injury referred to, operate as a complication, or contribute to produce death?_____________________________________
    If so, what?____

13. Was an alcohol and/or drug screen performed? No___________________Yes______________________________

14. Was the Insured confined in a hsopital? No___________________Yes______________________________

    From:___________________________To_______________________________

____ ____
Attending Physician Signature Date

____
Street

____
City, state, zip code

____
Telephone Number Fax