

Accidental Death and Dismemberment Claim Form

Policyholder Information

Full Name:

Policy Number:

Date of Birth:

Claim Details

Date of Accident:

Description of Accident:

Type of Injury (check all that apply):

☐ Death

☐ Dismemberment

Beneficiary Information (if applicable)

Beneficiary Name:

Relationship to Policyholder:

Supporting Documents

Attach relevant documents:

Choose File

No file selected

Submit Claim