1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH REQUIRED DOCUMENTATION
3. MAIL TO *HSR*

In addition to the claim form, the following items are required:

1. A Certified Copy of the final death certificate;
2. The Police Report, any Autopsy Report, and any newspaper clippings.

E-MAIL: StarrTravelClaims@hsri.com

HSR Plaza II
4100 Medical Parkway
Carrollton, Texas 75007
972-512-5600, Fax 972-512-5820
Toll Free: 866-345-0975

Policy Name: ______________________

Policy Number: ______________________

ACCIDENTAL DEATH CLAIM FORM

(Please print or type except where signature is required)

Insured's Information:

1. Insured's Name: ______________________ 2. Social Security Number: ______________________

3. Insured's Address: ______________________

4. Date of Birth: ____/____/______ 5. Place of Birth: ______________________ 6. Date of Death: ____/____/______

7. Date of Accident: (mm/dd/yyyy) ____/____/______

Place of Accident: ______________________
(Town) (Country) (State)

8. Describe fully how the accident occurred and the nature of injuries received.

____

____

9. Did the death of the insured arise out of or in the course of his or her employment? ____ Yes ____ No

10. Name and Address of Attending Physician(s) ______________________

____

Beneficiary Information:

11. Name of Beneficiary: ______________________ Relationship to Insured: ______________________

Date of Birth: ____________ Social Security Number: ______________ Telephone Number: ______________

Beneficiary's Address: ______________________

To be completed if death resulted from Motor Vehicle Accident:

12. Type of Vehicle ______________________ Registered Owner ______________________

Was deceased the driver? ___ Yes ___ No Was deceased a passenger? ___ Yes ___ No Was deceased a pedestrian? ___ Yes ___ No

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

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 Beneficiary or Next of Kin:____ Date ____________________

INSTRUCTIONS

1. The Company reserves the right to obtain further information should it be deemed necessary.
2. When benefits are payable to the estate of the insured, the Benefit Application must be executed by the executor or administrator and a certificate from proper court indicating the appointment must be furnished.
3. When benefits are payable to a minor, the Benefit Application must be executed by a guardian and a certificate from proper court indicating the appointment must be furnished.
4. When there is no attending physician, a certified copy of the verdict or finding of the coroner or other investigating official is required.
5. If coverage is through a rental car agency, attach a legible copy of the rental agreement.

I agree that the insurance company shall not be held to admit validity of any claim or waive the breach of any condition of the policy by furnishing this blank and investigating this claim.

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

Dated at ____________________________________ X____

(Beneficiary sign here)

On __________________________________, 2_____

MAIL ALL NECESSARY DOCUMENTATION TO:

***HSR* Plaza II**
4100 Medical Parkway
Carrollton, Texas 75007