HSR
Health Special Risk, Inc.
HSR Plaza II
4100 Medical Parkway, Carrollton, Texas 75007
Toll Free (800) 328-1114

PROOF OF ACCIDENTAL DEATH AND BENEFIT APPLICATION

(Please print or type except where signature is required)

Policy Name: Boy Scouts of America Policy Number: _____

Check One: ☐ **Tiger Cub** ☐ **Tiger Cub Adult** ☐ **Cub** ☐ **Scout** ☐ **Venturer** ☐ **Varsity Scout**
☐ **Leader** ☐ **Committee** ☐ **Learning for Life – Curriculum Based** ☐ **Explorer**
☐ **Volunteer Seasonal Staff** ☐ **Family Member**

Check Policy: ☐ **Council** ☐ **Unit** ☐ **Campers & Special Events** ☐ **National Events**

Check One: Are you a member of, or is your unit sponsored by the Church of Latter Day Saints?
☐ **Yes** ☐ **No** **Any participant in an LDS sponsored unit is ineligible for coverage under this policy because their Church has already provided insurance through another company, Deseret Mutual (1-800-777-3622).**

1. Name of Insured: _____
2. Date of Birth (mm/dd/yyyy): _____
3. Address of Insured: _____

   _____
4. a. Date of Accident (mm/dd/yyyy): _____

   b. Place of Accident: _____
   (Town) (Country) (State)

   c. Date of Death (mm/dd/yyyy) _____
5. Describe fully how the accident occurred and the nature of injuries received and if motor vehicle involved, whether deceased was operator, passenger or pedestrian.

   _____

   _____
6. Did the death of the insured arise out of or in the course of his or her employment? Yes ☐ No ☐
7. Name and Address of Attending Physician(s): _____

   _____
8. a. State the name of the beneficiary: _____

   b. State the beneficiary's mailing address: _____

   _____

   c. Are you the beneficiary described in the certificate and entitled to the proceeds thereof? Yes ☐ No ☐

   d. State your relationship, if any, to insured: _____

   e. State your Date of Birth: (mm/dd/yyyy) _____

IMPORTANT! **OFFICIAL BOARD OF HEALTH CERTIFICATE OF DEATH MUST BE FURNISHED. ALSO, ATTACH HOSPITAL RECORD AND NEWSPAPER ACCOUNTS, IF OBTAINABLE.**

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.

Dated at _____ **X**_____
(Beneficiary sign here)

On _____**, 20**__

The signature of the beneficiary must be witnessed, in the space provided below, by a notary public or attorney at law.

_____ _____
(Witness to Signature of Beneficiary) **(Title)**

Given under my hand and seal of office this _____ **day of** _____ **_____, 20__**

_____
Notary Public or Attorney at Law

(Personalized Notary seal)

_____
Print name of Notary Public here

My commission expires the _____ **day of** _____**, 20__**

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.**

MAIL ALL NECESSARY DOCUMENTATION TO:

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