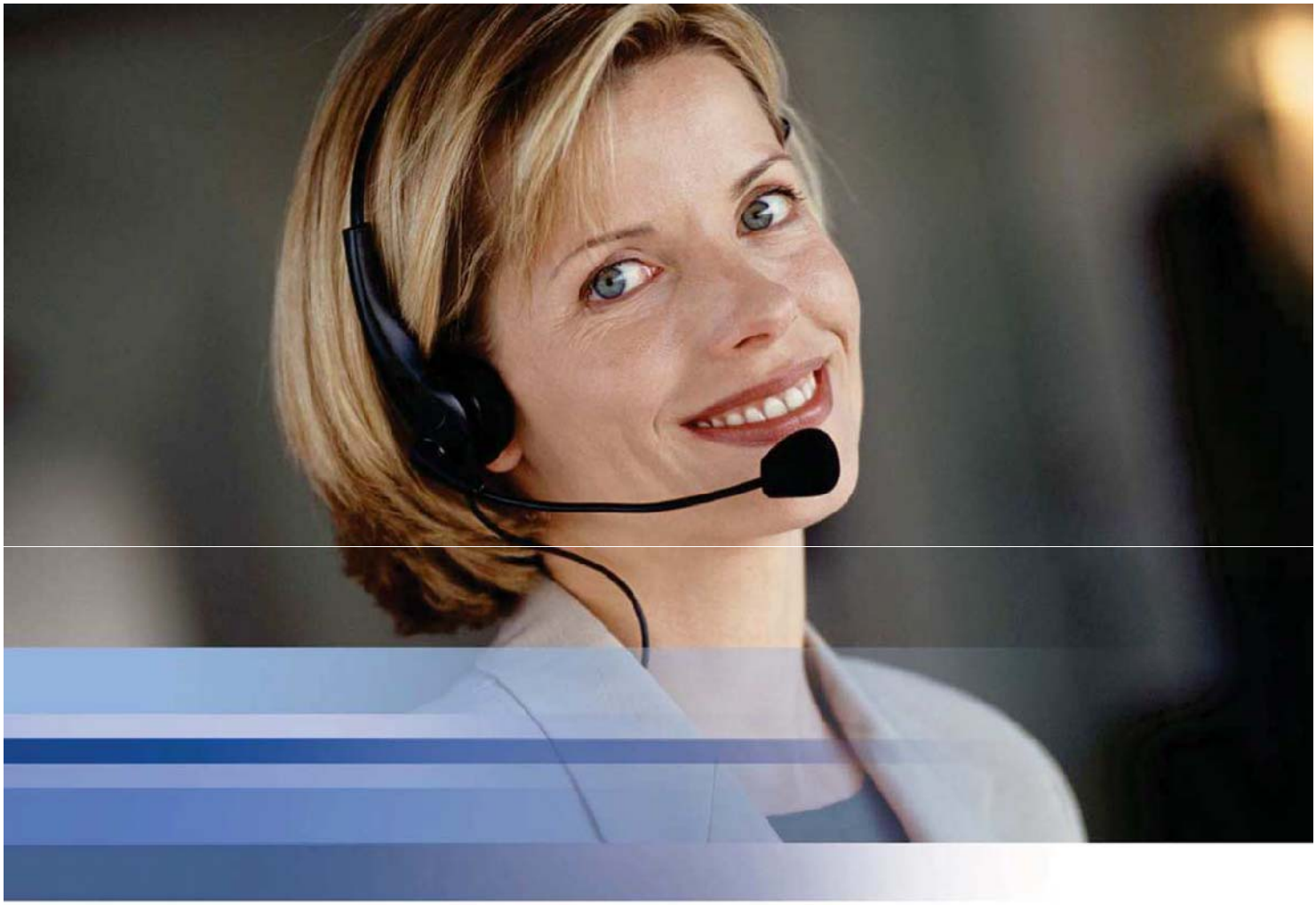

# A&H Claims

## Service Only a Strong Leader Can Provide

AIG

*Comprehensive Strength, Innovative Solutions®*

## About A&H Claims Department

**We realize our clients look to us not only for financial strength, but for superior service in every aspect of our performance — from our broad product portfolio and expert underwriting to claims services, arguably the defining element in our relationship with the people we serve.**

### Why We Can Promise Unsurpassed Claims Service

A&H Claims professionals are experienced troubleshooters.
We have the resources at our fingertips to immediately respond to inquiries and resolve claims.
We apply smart technologies to fine-tune our claims service and maximize efficiency.
We employ stringent internal quality control measures to closely monitor our performance.
Our services are proactive and available around the world.

### Our Strength Begins with Our People

The goal of A&H Claims is the skillful evaluation and swift resolution of every claim. To make sure this commitment is met, we employ teams of specialists in accident and health claims, and we assign dedicated specialists to cases with complex needs. The people at A&H Claims embody our standards for service excellence. Our claims specialist unit is staffed with seasoned supervisors and examiners cross-trained in all facets of claims processing. These knowledgeable professionals have the expertise to provide the right solutions and the authority to implement them. What's more, our people are warm, patient and particularly sensitive to difficult situations. We also provide specialized claims support exclusively for the needs of our agents, brokers and consultants.

### Leading-Edge Technology Helps Us Deliver For You

By innovatively applying the latest technology to our information systems, A&H Claims optimizes claims management, speeds claims processing and facilitates cost-effective claims outcomes. We work in a virtually paperless environment. All claims records and historical information are scanned immediately into our state-of-the-art imaging system as the documents are received. This enables our claims representatives to instantly access the details they need to assist our customers. Moreover, our system is continually maintained and backed up to ensure we are always up and running.

### Our Strength Shows When You Call

We understand that our clients view their interaction with our team as the touchstone of the claims process.
A&H's Call Center is managed to ensure that the performance of our staff and our technological support results in an outstanding level of customer service for each of our clients.
Our Call Center operations are designed with the latest technology to optimize communications with our customers. Our sophisticated call management system is fully automated to minimize call transfers and hold times and provide every caller with exceptional service. And we are continually assessing Call Center volume, hold times and peak periods so that we are always staffed and ready to provide outstanding customer service.

### Business Hours

Our business hours are from 8:30 a.m. to 5 p.m. eastern time. After hours, customers may leave messages. We guarantee a return call within 24 hours.

### Global Support

Wherever our customers work or travel, claim information is only a phone call away. Our multilingual Call Center staff can respond to inquiries in a variety of languages to provide the assistance customers need.

## How to use this Document

**Please read through this entire document before submitting your claim. If you have any questions about your claim or the process, please contact us at 1-800-551-0824.**

**Included in this package are:**

All the required forms to file a claim

Detailed instructions for filling out forms and filing your claim

An outline of any information and/or documentation needed to process your claim

Mailing address to send all your claims forms and required documents

Contact information in case you have any questions along the way

Details on what you should expect when you file a claim

## Type of Insurance Coverage

### Accidental Death
Refers to a covered injury resulting in the insured's death.

### Accidental Dismemberment and Paralysis
Refers to a covered injury resulting in dismemberment or paralysis.

**The instructions refer by number to the claim form that you need to complete. If you are missing a form, or have any questions about the forms or claims process, please call:**

The Domestic A&H Claims Department at
1-800-551-0824

All claims processed are subject to verification of coverage and benefits as indicated in the policy. Payment of claim by another provider does not guarantee payment by the AIG Companies. This document provides only brief descriptions of the coverages available. The Policies contain reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in each Policy. If there are any conflicts between this document and each Policy, the Policy shall govern. Insurance is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY; American International Life Assurance Company of New York, with its principal place of business in New York, NY; and AIG Life Insurance Company, with its principal place of business in Houston, TX; The Insurance Company of the State of Pennsylvania, with its principal place of business in New York, NY. AIG Life does not solicit business in New York.

## Accidental Death Claim Procedure

Use the ***Accidental Death Claim Form*** included in this kit. If you do not have the correct form, please contact 1-800-551-0824. The form must be filled out in its entirety, and the required items listed in ***Step 5*** and ***Step 6*** must be included to ensure a timely claim response. Failure to do so will result in a delay of processing the claim.

**Step 1:** *Section A* – Must be filled out completely by the Policyholder.

**Step 2:** *Section B* – Due to recent tax laws – Beneficiary must fill this out completely

**Step 3:** *Section C* – Must also be filled out completely by the Beneficiary.

**Step 4:** Ensure form has all the necessary signatures

**Step 5:** Provide the following ***required*** documents with your claim form:

Certified Copy of final Death Certificate

**Step 6:** In addition to the above documents which are required for all claims, there may be other documentation required. Carefully read the following points to determine what additional documents may be necessary to process the claim:

If interim treatment was given between date of accident & date of death, attach the attending physician's statement

If Beneficiary is a minor – a Certified Copy of the Court Appointment naming the Guardian of the Estate (property) of the minor

If NO Beneficiary has been designated – a Certified Copy of the Court Appointment naming the Administrator or Executor of decedent's estate

**Step 7:** **Forward all documents to:**

AIG Claim Services – A& H Claims Department
P.O. Box 25987, Shawnee Mission, KS 66225-5987

## Accidental Dismemberment Claims Procedure

Use the ***Accidental Dismemberment/ Paralysis Claim Form*** included in this kit. If you do not have the correct form, please contact 1-800-551-0824. The form must be filled out in its entirety, and the required items listed in ***Step 6*** must be included to assure a timely claim response. Failure to do so will result in a delay of processing the claim.

**Step 1:** *Section A* – Must be filled out completely by the Policyholder.

**Step 2:** *Section B* – Due to recent tax laws – Claimant must fill this out completely

**Step 3:** *Section C* – Must also be filled out completely by the Claimant.

**Step 4:** *Section D* – Physician must fill out all the information in its entirety or attach fully itemized bills (showing dates of service, description of each service and nature of injury/diagnosis).

**Step 5:** Ensure form has all the necessary signatures

**Step 6:** Provide the following ***required*** documents with your claim form:

Information on other Insurance

**Step 7:** **Forward all documents to:**

AIG Claim Services – A& H Claims Department
P.O. Box 25987, Shawnee Mission, KS 66225-5987

## After you have submitted your claim

You will receive an Explanation of Benefits (EOB) explaining how your claim was processed. This document contains important information about your claim, including the status; please retain it for your records. If the claim has been denied (not paid), please refer to the Remark Code section. It may be that all that is needed is additional information to move the claim forward. Please review the EOB completely and call our office at 1-800-551-0824 should you have any questions.

## Common EOB Medical Claims Terms and Definitions

| | |
|---|---|
| **Provider** | The name of each billing party (doctor, hospital, radiography, office, etc. |
| **Service** | The start and end dates of any treatment. |
| **# of SVC** | The number of treatments provided. |
| **Total Charged** | Total amount billed by each provider in US dollars. |
| **Non-Covered**<br>The amount in US dollars that will NOT be reimbursed based on your policy. | Any amount the provider has billed that is more than is "Usual and Customary" (your policy only covers Usual & Customary charges). |

### Other Headings

**Amount Considered**
The net amount in US dollars being considered based on your policy.

**%**
The percentage of medical bill which is being covered.

**Amount Paid**
The amount in US dollars that will actually be paid out.

**Checks Issued – Payee Name**
Person or provider to whom reimbursement check is actually made. If this is not you, your provider is being paid directly by the AIG Companies.

**Remark Code**
A numerical code which is explained in English under Description of Remark Codes.

**Usual & Customary**
Standard industry statistics showing the prevailing charge in the same geographic area for a given procedure.

## Appendix A - Claims Forms

The following pages contain all the claims forms that have been highlighted in this kit. You will find the type of claim form and the claim form number at the top of each form for easy identification. If you have any questions, or cannot find the appropriate form please contact AIG Claims services at 1-800-551-0824.

**ACCIDENTAL DEATH CLAIM FORM**

**ACCIDENTAL DISMEMBERMENT/PARALYSIS CLAIM FORM**

**PROOF OF LOSS - ACCIDENTAL DEATH CLAIM FORM**

AIG
Accident & Health Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987
800-551-0824 / fax: 866-831-3636

**NAME OF GROUP:**

**POLICY NUMBER:**

## GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Beneficiary. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Beneficiary will be required to complete PART B. Be certain that PART C on the reverse side is completed in full and signed by the Beneficiary.

Return this form to the above address.

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.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.

## PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

| DIVISION NAME AND ADDRESS | ACCIDENTAL DEATH BENEFIT IN FORCE $ |
|---|---|

| EMPLOYEE'S NAME AND ADDRESS | DATE EMPLOYED | DATE OFBIRTH |
|---|---|---|

| EFFECTIVE DATE OF COVERAGE | SOCIAL SECURITY NUMBER | DATE OF DEATH | OCCUPATION |
|---|---|---|---|

| TERMINATION DATE OF COVERAGE | INSURANCE CLASS | SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY) | DATE PREMIUM PAID TO |
|---|---|---|---|

DATE LAST WORKED

STATUS ON DATE LAST WORKED:

D ACTIVE D RETIRED D PREMIUM WAIVER FOR DISABILITY D APPROVED LEAVE OF ABSENCE (EXPLAIN) D OTHER

EMPLOYEE WAS: D HOURLY D SALARIED D COMMISSIONED D OTHER (EXPLAIN)

**If Claim is For Dependent, Provide the Following:**

| DEPENDENT'S NAME AND ADDRESS | SOCIAL SECURITY NUMBER | RELATIONSHIP | AMOUNT OF BENEFIT |
|---|---|---|---|

| DEPENDENT'S OCCUPATION | DEPENDENT'S DATE OF BIRTH | NAME AND ADDRESS OF EMPLOYER |
|---|---|---|

## GROUP POLICYHOLDER/EMPLOYER SIGNATURE

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

| DATE SIGNED | PLACE (CITY, STATE) | PHONE NUMBER |
|---|---|---|

| GROUP POLICYHOLDER/EMPLOYER | BY (THEIR AUTHORIZED REPRESENTATIVE) |
|---|---|

## PART B: IMPORTANT TAX INFORMATION

**To Be Completed by Beneficiary**
Social Security Number/
Tax ID Number

**Please Print or Type Name of Beneficiary**

Under penalties of perjury, I certify: that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

**Be Certain Part C on the Reverse Side is Completed**

## PART C: BENEFICIARY INFORMATION

In order to assure prompt processing, please be certain the authorization below is signed by the beneficiary. The completed and signed claim form along with the Certified Death Certificate, Police Report, Autopsy Report, and any newspaper clippings should be returned to the Employer/Administrator.

| NAME OF BENEFICIARY | RELATIONSHIP TO DECEDENT | BENEFICIARY'S DATE OF BIRTH |
|---|---|---|
| | | |

**NOTE:** If any designated beneficiary is deceased, submit that beneficiary's certified Death Certificate. If the beneficiary is the Deceased's estate, furnish certified letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If the beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and minor's social security number.

| WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR) | TIME D A.M. D P.M. | WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER) |
|---|---|---|
| | | |

| WHAT WAS CAUSE OF DEATH? | DATE OF DEATH (MO., DAY, YEAR) ATTACH COPY OF DEATH CERTIFICATE. |
|---|---|
| | |

WHEN DID SYMPTOMS OF CAUSE OF DEATH FIRST APPEAR?

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED FOR THE INJURIES CAUSING DEATH.

| NAME & ADDRESS | NAME & ADDRESS | NAME & ADDRESS |
|---|---|---|
| | | |

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED DURING THE LAST FIVE YEARS (STATE AILMENTS INVOLVED).

| NAME | ADDRESS | AILMENT |
|---|---|---|
| | | |
| NAME | ADDRESS | AILMENT |
| | | |

LIST ALL WITNESSES TO ACCIDENT.

| NAME & ADDRESS | NAME & ADDRESS | NAME & ADDRESS |
|---|---|---|
| | | |

LIST OTHER COVERAGES AND AMOUNTS OF INSURANCE IN FORCE ON DECEASED'S LIFE.

| NAME OF COMPANY | POLICY NUMBER | EFFECTIVE DATE | AMOUNT OF INSURANCE |
|---|---|---|---|
| | | | |
| NAME OF COMPANY | POLICY NUMBER | EFFECTIVE DATE | AMOUNT OF INSURANCE |
| | | | |

HAVE DIVORCE PROCEEDINGS EVER BEEN INSTITUTED BY OR AGAINST THE DECEASED? IF YES, INDICATE WHEN, WHERE AND THE OUTCOME.

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF**

### AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**For residents of New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto,commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.

**For residents of Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For claimants not residing in California, New York, or Pennsylvania**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

| SIGNATURE OF BENEFICIARY, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN | DATE SIGNED (MONTH, DAY, YEAR) | |
|---|---|---|
| | | |
| ADDRESS OF NEXT OF KIN (NO., STREET, CITY, STATE) | BUSINESS PHONE NUMBER | HOME PHONE NUMBER |
| | ( ) | ( ) |

## PROOF OF LOSS - ACCIDENTAL DISMEMBERMENT/PARALYSIS CLAIM FORM

AIG
Accident & Health Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987
800-551-0824 / fax: 866-831-3636

**NAME OF GROUP:**

**POLICY NUMBER:**

### GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please forward the claim form to the Claimant. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Claimant will be required to complete PART B. Be certain that PARTS C and D on the reverse side are completed in full and signed by the Claimant and Attending Physician, respectively. The Claimant is responsible for the completion of the Attending Physician's Statement without expense to the Company.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) Your company's enrollment benefits form;
(2) Confirmation of employee's principal sum and current premium payment;
(3) Information on other insurance;
(4) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of the trip, destination to and from trip, and confirmation that trip was authorized by the company.
(5) Please provide company name, address, phone number, and policy number.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary.

### PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

GROUP POLICYHOLDER/EMPLOYER ADDRESS

| | |
|---|---|
| DIVISION NAME AND ADDRESS | DATE EMPLOYED |
| EMPLOYEE/MEMBER NAME AND ADDRESS | DATE OF ACCIDENT |

| | | | |
|---|---|---|---|
| EFFECTIVE DATE OF COVERAGE | EMPLOYEE/MEMBER SOCIAL SECURITY NUMBER | DATE OF BIRTH | EMPLOYEE/MEMBER OCCUPATION |
| TERMINATION DATE OF COVERAGE | INSURANCE CLASS | SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY) | DATE PREMIUM PAID TO |

| | | | |
|---|---|---|---|
| ACCIDENTAL DEATH BENEFIT IN FORCE $ | DATE OF LAST BENEFIT INCREASE | IS EMPLOYEE/MEMBER RECEIVING W.C. BENEFITS? D YES D NO | IS EMPLOYEE/MEMBER RECEIVING ANY OTHER INSURANCE? D YES D NO |
| IF EITHER ANSWER IS YES, INDICATE NAME OF COMPANY: | | ADDRESS OF COMPANY | |

| | | |
|---|---|---|
| POLICY NUMBER | PHONE NUMBER | TYPE OF BENEFIT, BENEFIT AMOUNT, EFFECTIVE DATE |

STATUS OF EMPLOYEE/MEMBER ON DATE LAST WORKED

D ACTIVE D RETIRED D PREMIUM WAIVER FOR DISABILITY D APPROVED LEAVE OF ABSENCE (EXPLAIN) D OTHER

| | |
|---|---|
| DATE EMPLOYEE/MEMBER LAST WORKED | REASON EMPLOYEE/MEMBER DID NOT RETURN TO WORK |

EMPLOYEE/MEMBER WAS: D HOURLY D SALARIED D COMMISSIONED D OTHER (EXPLAIN)

**If Claim is For Dependent, Provide the Following:**

| | | | |
|---|---|---|---|
| DEPENDENT'S NAME AND ADDRESS | SOCIAL SECURITY NUMBER | RELATIONSHIP | AMOUNT OF BENEFIT |

| | | |
|---|---|---|
| DEPENDENT'S OCCUPATION | DEPENDENT'S DATE OF BIRTH | NAME AND ADDRESS OF EMPLOYER |

### GROUP POLICYHOLDER/EMPLOYER SIGNATURE

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

| | | |
|---|---|---|
| DATE SIGNED | PLACE (CITY, STATE) | PHONE NUMBER |
| GROUP POLICYHOLDER/EMPLOYER | BY (THEIR AUTHORIZED REPRESENTATIVE) | |

### PART B: IMPORTANT TAX INFORMATION

**To Be Completed by Claimant**
Social Security Number/
Tax ID Number

**Please Print or Type Name of Claimant**

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

**Be Certain Part C on the Reverse Side is Completed**

### PART C: CLAIMANT INFORMATION

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY) DESCRIBE INJURIES RECEIVED.

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED EMPLOYEE/MEMBER FOR THESE INJURIES

| NAME | ADDRESS | PHONE NUMBER |
|---|---|---|
| NAME | ADDRESS | PHONE NUMBER |

LIST ALL WITNESSES TO ACCIDENT

| NAME | ADDRESS | PHONE NUMBER |
|---|---|---|
| NAME | ADDRESS | PHONE NUMBER |

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF**

## AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**For residents of New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto,commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.

**For residents of Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For claimants not residing in California, New York, or Pennsylvania**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

| SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE | DATE SIGNED (MONTH, DAY, YEAR) | |
|---|---|---|
| ADDRESS OF CLAIMANT, OR AUTHORIZED REPRESENTATIVE(NO., STREET, CITY, STATE) | BUSINESS PHONE NUMBER ( ) | HOME PHONE NUMBER ( ) |

## PART D: ATTENDING PHYSICIAN'S STATEMENT

**THE CLAIMANT IS RESPONSIBLE FOR THE COMPLETION OF THIS STATEMENT WITHOUT EXPENSE TO THE COMPANY.**

| NAME OF PATIENT | AGE | ADDRESS (STREET, CITY, STATE, ZIP CODE) |
|---|---|---|

NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)

| WHEN DID ACCIDENT HAPPEN? (MO., DAY, YEAR) | WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? (MO., DAY, YEAR) |
|---|---|

DID THE ACCIDENTAL INJURY RESULT IN:

| | | | | | |
|---|---|---|---|---|---|
| LOSS OF HANDS? | O RIGHT O LEFT | WAS SEVERANCE AT OR ABOVE WRIST JOINT? | O YES O NO | DATE OF SEVERANCE | EXTANT OF SEVERANCE |
| LOSS OF THUMB AND INDEX FINGER OF SAME HAND? | O RIGHT O LEFT | WAS SEVERANCE THROUGH OR ABOVE METACARPOPHALANGEAL JOINT? | O YES O NO | DATE OF SEVERANCE | EXTANT OF SEVERANCE |
| LOSS OF FEET? | O RIGHT O LEFT | WAS SEVERANCE AT OR ABOVE ANKLE JOINT? | O YES O NO | DATE OF SEVERANCE | EXTANT OF SEVERANCE |

TOTAL AND IRRECOVERABLE RIGHT EYE O YES O NO DATE OF LOSS _____ WAS EYE REMOVED? O YES O NO DATE REMOVED_____

LOSS OF SIGHT OF: LEFT EYE O YES O NO | DATE OF LOSS | WAS EYE REMOVED? O YES O NO | DATE REMOVED

TOTAL AND IRRECOVERABLE LOSS OF HEARING IN BOTH EARS? O YES O NO DATE OF LOSS

☐ PARALYSIS ☐ QUADRIPLEGIA ☐ PARAPLEGIA ☐ HEMIPLEGIA

IN YOUR OPINION, WAS ANY DISEASE, INFECTION, BODILY OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?

IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF-INFLICTED INJURY OR ATTEMPTED SELF-DESTRUCTION? D YES D NO

IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGHT, PLEASE ANSWER THE FOLLOWING QUESTIONS:
IF THE LOSS OF SIGHT IS PARTIAL, BUT IRRECOVERABLE, PLEASE STATE AMOUNT OF VISION IN EACH EYE WITH SNELLEN NOTATIONS, OR JAEGER SCALE, IF PERTINENT.

| UNCORRECTED | | CORRECTED | | DATE OF EXAMINATION |
|---|---|---|---|---|
| O.D. | O.S. | O.D. | O.S. | |

DO YOU BELIEVE VISION CAN BE RESTORED IN WHOLE OR IN PART BY TREATMENT OR OPERATION? D YES D NO

IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE.

WAS PATIENT CONFINED TO A HOSPITAL? D YES D NO IF "YES," GIVE NAME AND ADDRESS OF HOSPITAL.

**TREATMENT**

| DATE OF FIRST VISIT | DATES OF SUBSEQUENT VISITS | | | |
|---|---|---|---|---|
| | | | | |

| SIGNATURE OF ATTENDING PHYSICIAN | PHYSICIAN'S NAME (PLEASE PRINT) | DEGREE | TELEPHONE ( ) | DATE |
|---|---|---|---|---|
| STREET ADDRESS | CITY OR TOWN | | STATE OR PROVINCE | ZIP CODE |

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? O YES O NO

IF DISCHARGED, GIVE DATE OF DISCHARGE:

**AIG**
Accident & Health Claims Department
PO Box 25987
Shawnee Mission, KS 66225

800 551 0824 Telephone
866 893 8574 Facsimile
AHClaims@AIG.com

Date

Dear Policyholder,

Attached is a copy of the Corporate Accident Medical claim form you requested. Please read the following information and instructions very carefully as all of the information is required for us to begin reviewing your claim.

All appropriate sections of the claim form must be completed in detail paying special attention to the following:

- Policyholder/Employer Instructions:
  - Employer must complete section A in it's entirety and be sure to sign and date claim form at the top of page 2.
  - Employer should submit the following with the claim form:
    - Enrollment benefits form for claimant
    - Confirmation of employee's Principal Sum and current premium payment
    - Police report and/or any other applicable documents
    - Copy of employee's itinerary to include purpose of trip, destination to and from, and authorization that the trip was authorized by the company
- Claimant/Employee Instructions:
  - Claimant should complete/review entire claim form for completeness and accuracy and complete section B if not completed by employer. The claimant must sign and date form at bottom of page 2.

Once your claims package is received, it will take approximately 10-15 business days to review your claim. Failure to submit all requested documents could result in a delay of the claims process. Please keep in mind that all decisions regarding claims will be made by the Claims Department and will be based on the documentation provided when the claim is filed.

If you have questions/comments, please contact our Customer Service Department at 1-800-551-0824.

Regards,

Customer Service Department
AIG

**AIG**
**Accident and Health Claims**
**P. O. Box 25987**
**Shawnee Mission, KS 66225**
**800-551-0824 (Telephone)**
**866-831-3636 (Facsimile)**

# PROOF OF LOSS - CORPORATE ACCIDENT - MEDICAL EXPENSE

**NAME OF GROUP:**

**POLICY NUMBER:**

## GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please complete PART A and PART B and forward the claim form to the Claimant. The Employer/Administrator must complete PART A in its entirety. Be certain that PART B is completed in full and signed by the Claimant.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) Your company's enrollment benefits form;
(2) Confirmation of employee's Principal Sum and current premium payment;
(3) The Police Report and any newspaper clippings.
(4) 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.
(5) If claimant is treated in the hospitalor by a doctor, please attach an itemized hospital bill.
(6) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.

## PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION

| | | | |
|---|---|---|---|
| GROUP POLICYHOLDER/EMPLOYER ADDRESS | | | MEDICAL BENEFIT IN FORCE $ |
| DIVISION NAME AND ADDRESS | | Do you have a Social Security Number ☐Yes ☐No (if yes please provide) | Social Security Number |
| EMPLOYEE'S NAME AND ADDRESS | | DATE OF BIRTH | GENDER ☐ MALE ☐ FEMALE |
| DATE EMPLOYED | EFFECTIVE DATE OF COVERAGE | DATE OF ACCIDENT | OCCUPATION |
| TERMINATION DATE OF COVERAGE | INSURANCE CLASS | SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLY) | DATE PREMIUM PAID TO |
| DATE LAST WORKED | STATUS ON DATE LAST WORKED: ☐ ACTIVE ☐ RETIRED ☐ PREMIUM WAIVER FOR DISABILITY ☐ APPROVED LEAVE OF ABSENCE (EXPLAIN) ☐ OTHER | | |

EMPLOYEE IS: ☐ HOURLY ☐ SALARIED ☐ COMMISSIONED ☐ OTHER (EXPLAIN)

**If Claim is For Dependent, Provide the Following:**

| | | | | |
|---|---|---|---|---|
| DEPENDENT'S NAME AND ADDRESS | ☐ MALE ☐ FEMALE | SOCIAL SECURITY NUMBER | RELATIONSHIP | AMOUNT OF BENEFIT |
| DEPENDENT'S OCCUPATION | U. S. CITIZEN ☐ YES ☐ NO | DEPENDENT'S DATE OF BIRTH | NAME AND ADDRESS OF EMPLOYER | |

**Please Be Certain the Next Page is Completed**

## PART A (Cont.): GROUP POLICYHOLDER/EMPLOYER SIGNATURE

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

| DATE SIGNED | PLACE (CITY, STATE) | PHONE NUMBER |
|---|---|---|
| | | |

| GROUP POLICYHOLDER/EMPLOYER | BY (THEIR AUTHORIZED REPRESENTATIVE) |
|---|---|
| | |

## PART B: Insured Information

OTHER HEALTH INSURANCE COVERAGE? (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY. NAME OF EMPLOYER AND POLICY NUMBER.) ☐ YES ☐ NO

| WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR) | TIME ☐ A.M. ☐ P.M. | WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER) |
|---|---|---|
| | | |

WHEN DID SYMPTOMS FIRST APPEAR?

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

SUPERVISOR'S NAME AND TELEPHONE NUMBER:

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF**

**AUTHORIZATION**

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

**California** :For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Rhode Island** : Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For residents of New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

**For residents of Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For claimants not residing in California, Rhode Island, New York, or Pennsylvania**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**I authorize payment of medical benefits to the physician or supplier for service performed.** ☐ **Yes** ☐ **No**

| SIGNATURE OF CLAIMANT | DATE SIGNED (MONTH, DAY, YEAR) |
|---|---|
| | |