

**AIG Life Insurance Company**

AIG Domestic Claims Inc.  
 A&H Claims Department  
 P. O. Box 25987  
 Shawnee Mission, KS 66225  
 800-551-0824 (Toll)  
 302-661-4176 (Direct)  
 866-893-5984 (Fax)

**PROOF OF LOSS****NAME OF GROUP:****POLICY NUMBER:****SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM****INSTRUCTIONS:**

- 1.) You must have **SECTION A** fully completed by a designated official of the Policyholder.
- 2.) **SECTION B** is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
- 3.) 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. **PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.**

**PRIMARY PLAN** - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

**EXCESS PLAN** - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

**SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER**

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)

SOCIAL SECURITY NO. (IF AVAILABLE)

DATE OF BIRTH

NAME OF SUPERVISOR

DATE COVERAGE BEGAN

DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)

DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY

DID ACCIDENT OCCUR:

A. WHILE CLAIMANT WAS SUPERVISED

 YES NO

B. DURING SPONSORED ACTIVITY

 YES NO

INDICATE THE SPORT (IF APPLICABLE)

C. DURING PROGRAMMED HOURS

 YES NO

D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP

 YES NO

DATE LAST WORKED

DATE RETURNED TO WORK

WEEKLY EARNINGS

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)

TITLE

DAYTIME TELEPHONE NUMBER

( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE

DATE

**SECTION B - MUST BE COMPLETED**

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:

POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)

GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)

EMPLOYER'S DAYTIME TELEPHONE #

( )

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

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.

I authorize payment of medical benefits to the physician or supplier for service performed.  YES  NO

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 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE

DATE

