AIG

AIG
Group Benefits

American General Life Insurance Company*
Houston, Texas
The United States Life Insurance Company in the City of New York
New York, New York
*This company does not solicit business in New York

Proof of Accidental Injury, Dismemberment
Claimant's Statement
PO Box 14294, Lexington, KY 40512
Tel +1 800-289-2266
Fax +1-855-864-0530
Email: claimsubmission@groupclaims.com

PLEASE ANSWER ALL QUESTIONS FULLY AS THIS WILL HELP EXPEDITE THE EVALUATION OF THIS CLAIM.

CLAIMANT'S STATEMENT:

1. Complete, Sign and Date Your Portion of the Claim Form Including the Authorization for Release of Information and the Fraud Statement.
2. Have Your Physician Complete the Attending Physician's Statement.
3. Send All Documents to the Address Listed Above.

COMPLETE FOR ALL CLAIMS

Policy Number:	Name of Group:		
Name of Employee:			
Date of Birth:	Social Security Number:	Tax I.D. Number:	Telephone Number:
Address:	City:	State:	Zip Code:

COMPLETE FOR DEPENDENT CLAIMS ONLY

Dependent's Name:	Relationship to Insured: ☐ Spouse ☐ Dependent Child ☐ Other		
Address:	City:	State:	Zip Code:
Full Time Student ☐ Yes If "Yes" and 18 Years or Older, Name of School: ☐ No			
Address:	City:	State:	Zip Code:

COMPLETE FOR ALL CLAIMS

Date of Injury:	Nature of Injury:

Briefly Describe How Injury Occurred: _____

Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or correct Taxpayer ID number; and (2) that I am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien).The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) in this paragraph if you are subject to backup withholding and cross out item (3) in this paragraph if you are not a U.S. person (including a U.S. resident alien).

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE FURNISHING OF FORMS BY THE COMPANY DOES NOT CONSTITUTE AN ADMISSION THAT THERE IS ANY INSURANCE IN FORCE.

Claimant's Name (If other than the Insured):		
Claimant's Date of Birth:	Claimant's Taxpayer ID# (SSN or ETIN, whichever is applicable):	
Employee's Name (Print):		
Signature of Employee, with Title, if any (U.S. person, including a U.S. resident alien):		Date:
Witness's Name (Print):	Witness's Signature:	Date:

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COMPLETE FOR ALL CLAIMS: ***ATTACH COPIES OF MEDICAL RECORDS AND ALL OPERATIVE REPORTS FOR THE CLAIMED INJURY AND LOSS.***

Name of patient: _____

Date of accident: _____ Date you last treated for this accident: _____

Is patient under care for any other illness or medical disorder? ☐ Yes ☐ No ☐ Unknown

If Yes, list diagnosis: _____

Did the underlying medical disorder contribute to the loss? ☐ Yes ☐ No ☐ Unknown

Are you the patient's regular physician? ☐ Yes ☐ No If No, physician's name: _____

Address: _____

Briefly describe accident: _____

Diagnosis and description of injuries: _____

_____

Was patient hospitalized? ☐ Yes ☐ No If Yes, Admission Date: _____ Discharge Date: _____

Hospital Name: _____

Address: _____

COMPLETE FOR DISMEMBERMENT ONLY:

Loss: ☐ Right Arm ☐ Left Arm at ☐ Elbow ☐ Shoulder ☐ Hand ☐ Fingers, list digits: _____

☐ Right Leg ☐ Left Leg ☐ Below Knee ☐ Above Knee ☐ Below Foot ☐ Above Foot ☐ Above Ankle ☐ Below Ankle

Date of amputation: _____

COMPLETE FOR DISMEMBERMENT AND/OR LOSS OF USE:

Function totally and irrecoverably lost? ☐ Yes ☐ No ☐ Hand ☐ Fingers ☐ Hemiplegia ☐ Paraplegic ☐ Quadriplegic

☐ Other (coma, hearing, etc.) please describe: _____

COMPLETE FOR LOSS OF SIGHT/VISUAL IMPAIRMENT:

Visual Acuity at last observation Date: _____ Uncorrected ☐ Right Eye ☐ Left Eye

Date: _____ Corrected ☐ Right Eye ☐ Left Eye

Is loss entire and irrevocable? ☐ Right Eye ☐ Left Eye ☐ Yes ☐ No Date deemed entire and irrevocable: _____

COMPLETE FOR ALL CLAIMS

Were the injuries received in the accident on the date specified solely and independently the cause of loss? ☐ Yes ☐ No

Did the accident arise out of employment or occur while patient was working? ☐ Yes ☐ No

Did this injury cause any period of disability? ☐ Yes ☐ No Last date worked: _____ Return to work date: _____

If currently disabled, estimate return to work date: _____

Briefly describe the duties the patient is unable to perform: _____

List any other facts you feel will assist us in our review: _____

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Physician Completing This Form (Print)	Signature:	Date:

Address:	City:	State:	Zip Code:

Telephone Number:	Fax Number:

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM, THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY.

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Authorization for Release of Information
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Email: claimsubmission@groupclaims.com

CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company and The United States Life Insurance Company in the City of New York (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinement for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG Company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the constestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG Company Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: AIG-Group Benefits, PO Box 14294, Lexington, KY 40512. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

NAME OF CLAIMANT (PRINT)

SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE

DATE

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FRAUD WARNING

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: 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.

California: For your protection California law requires the following to appear in 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding and attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provided false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana, Oklahoma: WARNING – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim, containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia, Maine, Tennessee, Virginia, Washington: WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with a purpose to injure, defraud any insurance company or other person files an application for insurance or statement or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 pernalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a mixiumum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years.

SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE

DATE