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
National Union Fire Insurance Company of Pittsburgh, Pa.
New York, New York
*This company does not solicit business in New York

Group Hospital Accident
Claim Form
PO Box 1130, Beattyville, KY 41311
Tel +1 800-348-6908

INSTRUCTIONS

1. Fully complete the Insured/Claimant's Information section.
2. Read the Fraud Statement section and sign and date in the space provided. **Failure to sign the Fraud Statement may delay the processing of your claim.**
3. Read the HIPAA Authorization section and sign and date in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. **Failure to sign the authorization may delay the processing of your claim.**
4. For the Dislocation, Fracture, Paralysis, Coma or Severe Burn benefits, have your attending physician complete the Attending Physician Statement section of the form.
5. Attach fully itemized bills from your health care providers. An itemized bill contains: the patient's name; the date(s) services were rendered; a description of the services rendered; the CPT/Revenue code(s) for each service and the fee for each service; the diagnosis or ICD-10 code; and the name, address, telephone number, professional status and Federal Tax Identification number of the health care provider.
6. Retain copies of your bills for your records.
7. Mail, fax, or Email your claim to: AIG's Group Benefits
   P.O. Box 1130
   Beattyville, KY 41311
   Fax: (888) 446-3205
   Email: Med_claims@aig.com

INSURED/CLAIMANT'S INFORMATION SECTION

Name of Insured (first, middle initial, last) (Please Print)	Certificate Number	Policy Number

Insured's Address, Street & No.	City	State	Zip

Phone No.	Date of Birth	Male ☐ Female ☐

Patient's Name for whom claim is being made (first, middle initial, last)	Patient's Relationship to Insured	Single ☐ Married ☐

Patient's Address, Street & No.	City	State	Zip

Patient's Sex Male ☐ Female ☐	Patient's Date of Birth	If over age 19 and attending school or college, Provide Proof of Full Time Student Status

Is claim related to an accident? Yes ☐ No ☐	If Yes, what was date of accident?	If Yes, how and where did the accident occur?

What injury/injuries did you sustain in the accident?	Date first treated for injury?	Is condition related to employment? Yes ☐ No ☐ Is condition related to an auto accident? Yes ☐ No ☐

If hospitalized, give name and address of hospital	Dates of confinement

Treating Physician's Name	Treating Physician's Telephone Number

Treating Physician's Address, Street & No.	City	State	Zip

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Fraud Statement
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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 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.
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 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 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 penalties.
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 maximum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years.

Signature of Insured ____________________ Date ____________________

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HIPAA Authorization
PO Box 1130, Beattyville, KY 41311
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Health Insurance Portability and Accountability Act ("HIPAA")

Authorization to Obtain and Disclose Information

Claimant's Name	Date of Birth	Social Security Number (Insert last 4 digits of SS# only)

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and National Union Fire Insurance Company of Pittsburgh, Pa., collectively the "Companies", and their authorized representatives, as well as other 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 confinements 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 contestability 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 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's Group Benefits, P.O. Box 1130, Beattyville, KY 41311. 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.

______________________________ ______________________________
Signature of Claimant or Claimant's Personal Representative Date

____
Description of Authority of Personal Representative (if applicable)

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Attending Physician's Statement Section
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ATTENDING PHYSICIAN'S STATEMENT

Patient's Name		Date of Birth	Date of Death (if applicable)
Date of Accident?	When did signs and/or symptoms first appear?	Has the patient ever received medical advice or treatment for this or a similar condition? ☐ Yes, when ______________________. ☐ No	Diagnosis (including complications)

DISLOCATIONS

Did the patient suffer a dislocation, which required reduction under anesthesia? **Attach a copy of the operative report(s).** ☐ Yes ☐ No

Please specify dislocation(s):

☐ Ankle – Right ☐ or Left ☐
☐ Collar Bone – Right ☐ or Left ☐
☐ Elbow – Right ☐ or Left ☐
☐ Hip – Right ☐ or Left ☐
☐ Jaw – Right ☐ or Left ☐
☐ Knee – Right ☐ or Left ☐
☐ Shoulder – Right ☐ or Left ☐
☐ Wrist – Right ☐ or Left ☐

FRACTURES / CONCUSSION

Did the patient suffer a fracture? **Attach a copy of the Radiology Report(s).** ☐ Yes ☐ No

Has the patient ever suffered an osteoporosis or pathological fracture?
☐ Yes, when ______________________.
☐ No

Please specify fracture(s) or concussion:

☐ Ankle	☐ Elbow	☐ Heel	☐ Lower Leg	☐ Shoulder Blade	☐ Upper Arm
☐ Cheek Bone	☐ Foot	☐ Hip	☐ Neck	☐ Skull	☐ Vertebra
☐ Coccyx	☐ Forearm	☐ Kneecap	☐ Pelvis	☐ Sternum	☐ Wrist
☐ Collar Bone	☐ Hand	☐ Lower Jaw	☐ Rib	☐ Thigh	☐ Concussion

PARALYSIS

Under the provisions of this policy, Paralysis/Paralyzed means Quadriplegia, Paraplegia or Hemiplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the accident causing Paralysis or the date of the diagnosis.

"Quadriplegia" means the complete and irreversible Paralysis of both upper and lower limbs.
"Paraplegia" means the complete and irreversible Paralysis of both lower limbs.
"Hemiplegia" means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body.
"Uniplegia" means the complete and irreversible paralysis of one limb.
"Limb" means entire arm or entire leg.

Is the patient paralyzed as the result of a sickness or injury? **Attach documentation of the sickness or injury that caused the paralysis.** ☐ Sickness ☐ Injury

What sickness or injury caused the paralysis?

Did the patient's sickness or injury result in Quadriplegia? ☐ Yes ☐ No

Did the patient's sickness or injury result in Paraplegia? ☐ Yes ☐ No

Did the patient's sickness or injury result in Hemiplegia? ☐ Yes ☐ No

Did the patient's sickness or injury result in Uniplegia? ☐ Yes ☐ No

COMA

Was the patient in a profound state of unconsciousness that lasted for a period of at least 96 hours and from which the patient could not be aroused to consciousness, even by powerful stimulation? ☐ Yes ☐ No

Was permanent neurological deficit present? ☐ Yes ☐ No

Was the patient's coma the result of a sickness or injury? ☐ Sickness ☐ Injury

SEVERE BURNS

Did the patient's injury cause cosmetic disfigurement of at least 20% of the surface of a body area due to a third-degree, full thickness burn? (A third degree, full-thickness burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock by means of exposure to fire, heat, caustics, electricity or radiation). ☐ Yes ☐ No

Date of injury that resulted in a second degree, partial thickness burn or a third-degree, full-thickness burn?

ATTENDING PHYSICIAN'S SIGNATURE

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

Name (attending physician) please print	Degree	Telephone number	
Address	City	State	Zip
Signature	Date	Medical State License#	