PROOF OF LOSS- ACCIDENTAL DISMEMBERMENT/PARALYSIS CLAIM FORM

AIG
Personal Accident and Health Claims Department
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Shawnee Mission, KS 66225
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UNDERWRITING CO:	
NAME OF GROUP:	
POLICY NUMBER:	

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

IN ORDER TO ASSURE PROMPT REVIEWING 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.

INSTRUCTIONS:
1.) THIS FORM IS TO BE USED WHEN FILING A CLAIM FOR REIMBURSEMENT OF MEDICAL EXPENSES OR HOSPITAL INDEMNITY BENEFITS.
2.) SECTION A MUST BE COMPLETED BY THE INSURED IN FULL.
3.) SECTION B MUST BE FULLY COMPLETED BY THE ATTENDING PHYSICIAN.
4.) FULLY ITEMIZED BILLS INCLUDING: CLAIMANT'S NAME, NATURE OF ILLNESS/INJURY, DESCRIPTION AND CHARGE FOR EACH SERVICE PROVIDED.
5.) THIS FORM MUST BE SIGNED AND DATED IN ALL APPLICABLE SECTIONS.
6.) THIS FORM AND ALL ATTACHED BILLS MUST BE SUBMITTED TO THE ADDRESS INDICATED ABOVE.

NEW YORK FRAUD STATEMENT: 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.

PART A: CLAIMANT'S STATEMENT

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME	DATE EMPLOYED

EMPLOYEE/MEMBER NAME AND ADDRESS	DATE OF ACCIDENT	EMPLOYEE/MEMBER OCCUPATION

EFFECTIVE DATE OF COVERAGE	EMPLOYEE/MEMBER SOCIAL SECURITY NUMBER	DATE OF BIRTH	CLAIMANT GENDER MALE FEMALE	U.S. CITIZEN YES NO

TERMINATION DATE OF COVERAGE	INSURANCE CLASS	SALARY ON DATE LAST WORKED	HRLY MTHLY	WKLY ANNLY	DATE PREMIUM PAID TO

ACCIDENTAL DEATH BENEFIT IN FORCE $	DATE OF LAST BENEFIT INCREASE	IS EMPLOYEE/MEMBER RECEIVING W.C. BENEFITS? YES NO	IS EMPLOYEE/MEMBER RECEIVING ANY OTHER INSURANCE? YES 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
ACTIVE RETIRED PREMIUM WAIVER FOR DISABLITY APPROVED LEAVE OF ABSENCE OTHER (EXPLAIN)

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

EMPLOYEE/MEMBER WAS: HOURLY SALARIED COMMISSIONED OTHER (EXPLAIN

IF CLAIM IS FOR DEPENDENT PROVIDE THE FOLLOWING:

DEPENDENT'S NAME AND ADDRESS	GENDER MALE FEMALE	SOCIAL SECURITY NUMBER	RELATIONSHIP	BENEFIT AMOUNT

DEPENDENT'S OCCUPATION	U.S. CITIZEN YES NO	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 OT 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 of 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

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 WITNESS TO ACCIDENT

NAME	ADDRESS	PHONE NUMBER
NAME	ADDRESS	PHONE NUMBER

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT OT 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.

SIGNATURE OF CLAIMANT OR AUTHORIZAED REPRESENTATIVE	DATE SIGNED (MONTH, DAY, YEAR)	
ADDRESS IF CLAIMANT OR AUTHORIZED REPRESENTATIVE (NO., STREET, CITY, STATE)	EMAIL ADDRESS	HOME PHONE

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, ICTY, 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?	RIGHT LEFT	WAS SEVERANCE AT OR ABOVE THE WRIST JOINT?	YES NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE
LOSS OF THUMB AND INDEX FINGER OF SAME HAND?	RIGHT LEFT	WAS SEVERANCE THROUGH OR ABOVE METACARPOPHALANGEAL JOINT?	YES NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE
LOSS OF FEET?	RIGHT LEFT	WAS SEVERANCE AT OR ABOVE ANKLE JOINT?	YES NO	DATE OF SEVERANCE	EXTANT OF SEVERANCE

TOTAL AND IRRECOVERABLE LOSS OF SIGHT OF:								
	RIGHT EYE	YES	NO	DATE OF LOSS	WAS EYE REMOVED?	YES	NO	DATE REMOVED
	LEFT EYE	YES	NO	DATE OF LOSS	WAS EYE REMOVED?	YES	NO	DATE REMOVED

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

PARALYSIS QUADRIPLEGIA PARAPLEGIA HEMIPLEGIA

IN YOUR OPINION, WAS ANY DISEAS, INFECTION, BODILY, OR MENTAL INFIRMITY AN UNDERLYING CAUSE IN THE LOSS(ES) INDICATED ABOVE?	YES	NO
IN YOUR OPINION, DID THE LOSS(ES) RESULT FROM ANY SELF INFLICTED INFJURY OR ATTEMPTED SELF-DESTRUCTION?	YES	NO

IF THE INDICATED LOSS(ES) INCLUDE LOSS OF SIGH, 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? YES NO

IF AN OPERATION IS CONTEMPLATED, GIVE APPROXIMATE DATE.

WAS PATIENT CONFINED TO A HOSPITAL? YES 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 OF THIS CONDITION? YES NO

IF DISCHARGED, GIVE DATE OF DISCHARGE:

FRAUD STATEMENTS

FOR USE ON ALL APPLICATIONS AND CLAIM FORMS

ALABAMA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

ALASKA: A PERSON WHO KNOWLINGLY 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 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 CIVIAL PENALTIES.

ARKANSAS, LOUISIANA, RHODE ISLAND, AND 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 FALSE OR FRADULENT CLAIM FOR THE PAYMENT OF A LOSS IS G UILTY 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 OR 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 PROVIDES 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: 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: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES 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.

IDAHO: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

INDIANA: A PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

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.

MAINE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

MARYLAND: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURNACE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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 CIVIAL PENALTIES.

NEW MEXICO: 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 CIVIL FINES AND CRIMINAL PENALTIES.

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.

OKLAHOMA: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

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 PURPSOSE 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.

TENNESSEE, VIRGINIA, AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

TEXAS: 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE:	DATE: