



Accident and Health Insurance Claim Form

American General Life Insurance Company, Houston, TX
The United States Life Insurance Company in the City of New York, New York, NY

Mail to: P.O. Box 818100, Cleveland, OH 44181

HOW TO SUBMIT YOUR CLAIM— PLEASE PRINT

- STEP 1. Complete Part A below as it applies to this claim. Date and sign for all claims.
STEP 2. Have your attending physician complete Part B.
STEP 3. When you and your attending physician have completed the form, in detail, attach the requested requirements and forward to us for review and processing to P.O. Box 818100, Cleveland, OH 44181 or fax to: 855-601-1834.

PART A TO BE COMPLETED BY INSURED

Please Note: Failure to complete this form IN FULL may delay the review of your claim.

- | | |
|----------------------------|---------------------------|
| 1. Policyholder Name _____ | 2. Policy Number(s) _____ |
| 3. Date of Birth _____ | 4. Home Phone _____ |
| 5. Home Address _____ | 6. Office Phone _____ |

Complete for Spouse/Dependent

- | | |
|---------------|------------------------|
| 7. Name _____ | 8. Date of Birth _____ |
|---------------|------------------------|
9. Full time student ☐ Yes ☐ No If "Yes" and 18 years or older submit proof of current school enrollment.

Complete for an Illness/Sickness Claim

Claim for Cancer: Submit the Pathology Report and Itemized bills

Claim for Hospital Confinement: Submit the Itemized Hospital bill

Claim for Critical Illness: Submit the medical records Re: Initial Diagnosis

10. Describe condition: _____
11. Date symptoms first noticed: _____ 12. Date first consulted physician _____

Complete for an Accident Claim

Requirements: The initial medical evaluation notes from emergency room, urgent care center or physician.

The itemized bills and copies of the Explanation of Benefits from your major medical plan or other insurance coinciding with the bills you are submitting.

13. Date of accident _____
14. Where did accident happen? _____
15. How did accident happen? _____
16. Is the insured/dependent covered under any other group health insurance or service plan or federal medicare/medicaid program? ☐ Yes ☐ No

Date and Sign

17. I certify that the above information is true and correct. A photographic copy of this certification shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files and 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.

Policyholder Signature

Policyholder signed on (date) _____

X

PART B TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Patient's Name _____ Date of Birth _____
2. Diagnosis and concurrent conditions: (Provide ICD-10 Codes.) _____

3. Report of Services

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	CPT CODE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
*O—Doctor's Office		IH —Inpatient Hospital	NH—Nursing Home
H—Patient's Home		OH—Outpatient Hospital	OL—Other Locations

4. Date symptoms first appeared or accident happened. _____
5. Date patient first consulted you for this condition. _____
6. Has patient ever had same or similar condition? ☐ No ☐ Yes If "Yes" when and describe. _____
7. Name of referring physician. _____
8. Is patient covered under any Health Insurance / Service plan / Government Program? ☐ No ☐ Yes
Name of Carrier: _____
9. Was patient hospital confined? ☐ No ☐ Yes Name of Hospital _____

Provider Tax ID Number: _____

Address _____

This will confirm that the patient _____ (is/was) a patient in
this hospital and is charged room and board for _____ days from _____ to _____.

Title: _____ Date _____

Signature: _____

Attending Physician Signature

X

Attending Physician signed on (date) _____**Physician's Name** (please print) _____**Telephone** _____**Address** _____

>>> Please detach & keep page <<<

FRAUD WARNING DISCLOSURE

In some states we are required to advise you of the following: Any person who knowingly intends to defraud or facilitates a fraud against an insurer by submitting an application or filing a false claim, or makes an incomplete or deceptive statement of material fact, may be guilty of insurance fraud.

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 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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 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, 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: 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.

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.

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 (\$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.