

AIG Life Insurance Company

AIG Claim Services
 A&H Claims Department
 P. O. Box 15701
 Wilmington, DE 19850-5701
 800-551-0824/302-661-4176

PROOF OF LOSS

NAME OF GROUP: NRPA

POLICY NUMBER:

ACCIDENT ACTIVITY 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.**
 - 4.) If claimant is treated by a doctor, have the doctor complete **SECTION C**, the Physician's Statement, or attach an itemized bill.
- 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.

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.

SECTION A -- FAILURE TO COMPLETE THIS SECTION MAY RESULT IN DELAY IN CLAIM PROCESSING.

NAME OF LEAGUE/CONFERENCE AND TEAM Coeur d'Alene junior Tackle Football			CERTIFICATE NUMBER 4194565-01		
CLAIMANT'S FULL NAME		SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF ACTIVITY SUPERVISOR	
DATE COVERAGE BEGAN 7/1/2007	DATE COVERAGE WILL END/HAS ENDED 7/1/2008	CLAIMANT IS/WAS: (CHECK ONE)			
		<input type="checkbox"/> LEAGUE/TEAM OFFICIAL <input type="checkbox"/> NON-LEAGUE OFFICIAL <input type="checkbox"/> COACH <input type="checkbox"/> PLAYER <input type="checkbox"/> CHEERLEADER			
NATURE OF INJURY (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)			DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).		
TYPE OF ACTIVITY	DID ACCIDENT OCCUR:				
INDICATE THE SPORT <input type="checkbox"/> TACKLE FOOTBALL <input type="checkbox"/> FLAG/TOUCH FOOTBALL	A. WHILE CLAIMANT WAS SUPERVISED		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	B. DURING SPONSORED ACTIVITY		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	C. DURING PROGRAMMED HOURS		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP		<input type="checkbox"/> YES	<input type="checkbox"/> 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 - CLAIMANT MUST COMPLETE

NAME OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	DAYTIME TELEPHONE NO. ()
ADDRESS OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	

OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY. NAME OF EMPLOYER AND POLICY NUMBER.)
 YES _____ NO _____

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.

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."
For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.
For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties."
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.

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

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE	DATE
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Section C

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (ID) OTHER <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN)				MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG				1a. INSURED'S I.D. NUMBER				
2. PATIENT'S NAME (First Name, Middle Initial, Last Name)			3. PATIENT'S DATE OF BIRTH MM / DD / YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (First Name, Middle Initial, Last Name)					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE NO. ()			6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY)			7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE NO. ()						
9. OTHER INSURED'S NAME A. OTHER INSURED'S POLICY OR GROUP NUMBER B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY SEX M <input type="checkbox"/> F <input type="checkbox"/> C. EMPLOYER'S NAME OR SCHOOL NAME D. INSURANCE PLAN NAME OR PROGRAM NAME			10. IS PATIENT'S CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> D. RESERVED FOR LOCAL USE			11. INSURED'S POLICY GROUP OR FECA NUMBER 3. PATIENT'S DATE OF BIRTH MM / DD / YY SEX M <input type="checkbox"/> F <input type="checkbox"/> B. EMPLOYER'S NAME OR SCHOOL NAME C. INSURANCE PLAN NAME OR PROGRAM NAME D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to & complete item 9 A-D						
12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature _____ Date _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to undersigned physician or supplier for service described below. Signature _____ Date _____							
14. DATE OF CURRENT: MM / DD / YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY / / /		16. Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM: / / TO: / /						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO: / /							
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1 _____ 3 _____ 2 _____ 4 _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER							
24. A DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H DPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office). PIN# _____ GRP# _____				33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #				
PLACE OF SERVICE CODES 1-(H) - INPATIENT HOSPITAL 2-(OH) - OUTPATIENT HOSPITAL 3-(O) - DOCTOR'S OFFICE		4-(H)-PATIENT'S HOME 5- -DAYCARE FACILITY (PSY) 6- -NIGHT CARE FACILITY(PSY)		7-(NH) NURSING HOME 8-(SNF)-SKILLED NURSING FACILITY 9- -AMBULANCE		O-(OL)-OTHER LOCATIONS A-(IL)-INDEPENDENT LABORATORY B- -OTHER						