



American General Life Insurance Company (AGL)

P. O. Box 4277, Houston, TX 77210-4277
Member of American International Group, Inc.

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. Complete Part B on the reverse side. The authorization to pay benefits to the physician is to be signed if you wish payment to be made directly to the health care provider.
STEP 3. Have your attending physician complete Part C on reverse side.
STEP 4. When you and your attending physician have completed the form, in detail, attach all related itemized medical bills and forward to the company for review and processing.

PART A TO BE COMPLETED BY INSURED

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

I. Complete For All Claims

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

II. Complete For Dependent Claims Only

- 8. Dependent's Name
9. Dependent's Date of Birth
10. Relationship: Spouse Son Daughter Other: Residence
11. Full time student Yes No If "Yes", and 18 years or older provide name and address of school:

III. Complete For All Claims

- 13. Describe condition:
14. Was condition cause by patient's employment? Yes No If "Yes" has or will a claim be filed with the worker's compensation carrier? Yes No Result? Accepted Denied Pending
15. Date symptoms first noticed:
16. Date first consulted physician
17. Name(s) and address(es) of physician(s) consulted for this condition or any similar related condition:
18. Did the injury or illness require hospital confinement? Yes No If "Yes" please provide the name of the hospital and dates confined:
19. Is person for whom claim is made covered under any other group health or service plan, or federal medicare program? Yes No
20. If "Yes" is other coverage: Employer Plan Union Plan Private Plan Student Plan Other:
A. Insured Member's Name
B. Policy/Member No.
C. Member's Soc. Sec. No.
D. Effective Date
E. Name, address, and phone number of insurance company or organization providing benefits or service:

IV. Complete For Accident Claims Only

- 21. Date of accident
22. Was patient at work when accident happened? Yes No
23. Where did accident happen?
24. How did accident happen?

V. Date and Sign for ALL Claims

25. I/We certify that the above information is true and correct. (If claim for spouse, spouse also must sign.) A photographic copy of this certification shall be considered as effective and valid as the original.

Date

Signature of Spouse

Signature of Policyholder

**PART B TO BE COMPLETED BY PATIENT/OR INSURED**

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: (OPTIONAL)**

I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

Date \_\_\_\_\_

Signature - Insured Person \_\_\_\_\_

**PART C TO BE COMPLETED BY ATTENDING PHYSICIAN**

1. Patient's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If patient is a minor,

Policyholder's name also: \_\_\_\_\_ Policy No.: \_\_\_\_\_

2. Diagnosis and concurrent conditions: (If diagnosis code other than ICD\* used, give name)

\_\_\_\_\_

3. Pregnancy?  Yes  No If "Yes" approximate date pregnancy commenced: Date: \_\_\_\_\_

4. Is condition due to injury or sickness arising out of patient's employment?  Yes  No

5. Report of Services (or attach itemized bill)\* (If previous form submitted to this carrier, you need show only dates and services since last report.)

DATE OF SERVICES	PLACE† OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CODE IF USED RVS** or CPT***	CHARGES
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

†0—Doctor's Office      IH —Inpatient Hospital      NH—Nursing Home      **TOTAL CHARGES** ▶ \$ \_\_\_\_\_

H—Patient's Home      OH—Outpatient Hospital      OL—Other Locations      **AMOUNT PAID** ▶ \$ \_\_\_\_\_

\*ICD — International Classification of Diseases      **BALANCE DUE** ▶ \$ \_\_\_\_\_

\*\*RVS — Relative Value Studies

\*\*\*CPT — Current Procedural Terminology (Current edition)

6. Date symptoms first appeared or accident happened. \_\_\_\_\_

7. Date patient first consulted you for this condition. \_\_\_\_\_

8. Patient ever had same or similar condition?  Yes  No If "Yes" when and describe. \_\_\_\_\_

\_\_\_\_\_

9. Patient still under your care for this condition?  Yes  No (If "No" give date your services terminated.)

\_\_\_\_\_

10. Was laboratory work performed outside your office? \_\_\_\_\_

11. Name of referring physician. \_\_\_\_\_

12. Patient was hospital confined.  Yes  No From \_\_\_\_\_ thru \_\_\_\_\_

Name of hospital \_\_\_\_\_

13. Is the person for whom claim is made covered under any other Health/Service plan?  Yes  No

Medicare?  Yes  No Med-Cal?  Yes  No (Med-Cal # \_\_\_\_\_)

Other Government/Welfare/Aid program?  Yes  No

DATE \_\_\_\_\_ SIGNATURE (Attending Physician) \_\_\_\_\_ TELEPHONE \_\_\_\_\_

PHYSICIAN'S NAME (Please Print) \_\_\_\_\_ TAX ID NO. \_\_\_\_\_ PATIENT'S ACCT. NO. \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ COUNTY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**IMPORTANT NOTICE**

**CALIFORNIA CLAIMANTS:** 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 confinements in state prison."

**ALL OTHER CLAIMANTS:** A law of your state requires us to inform you that any person knowingly and with intent to defraud any insurance company or other persons 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.