**American General**
Life Companies

# 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**

**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 4277, Houston, TX 77210-4277.**

**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.

_____ _____
Signature of Policyholder Date

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

1. Patient's Name_____ Date of Birth _____
2. Diagnosis and concurrent conditions: (Provide ICD-9 Code.)

   _____

   _____
3. Report of Services

| DATE OF SERVICE | PLACE OF SERVICE* | DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED | CPT CODE |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

*0—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: _____

DATE SIGNATURE (Attending Physician) TELEPHONE

PHYSICIAN'S NAME (Please Print)

STREET ADDRESS CITY 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.