14/15

AIG
Personal Accident Claims Department
P. O. Box 25987
Shawnee Mission, KS 66225
800-551-0824 (Telephone)
866-893-8574 (Facsimile)

**PROOF OF LOSS**

UNDERWRITTEN BY: National Union Fire Ins. Co. of Pittsburgh, Pa.

NAME OF GROUP: MHSAA (Michigan High School Athletic Assoc.)

POLICY NUMBER: SRG0009142462

# PERSONAL ACCIDENT 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.

☐ PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

☒ 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.

**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.**

## SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME OF SCHOOL | NAME OF SCHOOL DISCTRICT

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE) | SOCIAL SECURITY NO. MANDATORY | DATE OF BIRTH | GENDER: MALE ☐ FEMALE ☐

WAS THE ACCIDENT SCHOOL RELATED? YES ☐ NO ☐ | IS THE ACCIDENT COVERED UNDER A CATASTROPHIC POLICY YES ☐ NO ☐

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.) | DESCRIBE HOW (PLEASE PROVIDE ALL DETAILS), WHEN (DATE AND TIME) AND WHERE ACCIDENT OCCURRED.

NAME OF ACTIVITY

INDICATE THE SPORT (IF APPLICABLE)

DID ACCIDENT OCCUR:

| | | |
|---|---|---|
| A. WHILE CLAIMANT WAS SUPERVISED | ☐ YES | ☐ NO |
| B. DURING SPONSORED ACTIVITY | ☐ YES | ☐ NO |
| C. DURING PROGRAMMED HOURS | ☐ YES | ☐ NO |
| D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP | ☐ YES | ☐ NO |

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE) | TITLE | DAYTIME TELEPHONE NUMBER ( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE | DATE | NAME OF SUPERVISOR

## SECTION B - MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED: | POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN) | GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER) | EMPLOYER'S DAYTIME TELEPHONE # ( )

**I HEREBY AUTHORIZE ANY COMMUNICATION BETWEEN THE POLICY HOLDER AND AIG AND IT'S AFFILIATES IN REGARDS TO THE ABOVE MENTIONED CLAIM AND RELATED MEDICAL EVENTS.**

Signature _____ Date _____

**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.

**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE PERFORMED.** ☐ YES ☐ NO

**CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE** | **DATE**

# CLAIM INSTRUCTIONS

1. In case of an accident, notify the school/organization immediately.

2. Notify **ALL** treatment facilities (physician's office, hospital, etc.) of this insurance coverage so that any invoices and/or Explanation of Benefits (EOB) can be sent directly from the medical facility to AIG.

3. Have Part I and Part II completed on the Notification of Injury form. Do not leave any blank spaces or write "N/A" in any space. If either parent or guardian is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer that the claimant has no insurance. Otherwise, our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

4. Attach any itemized bills to the claim form, along with any corresponding Explanation of Benefits (EOB) for each itemized bill. An itemized bill includes treatment rendered, the dates of the treatment, diagnosis codes, physician's or hospital's name, address and tax i.d. number. Balance Due bills are not acceptable. Be sure to attach any receipts for bills paid out-of-pocket. Otherwise, benefits will be paid to the provider of service. Please Note: Both an itemized bill and EOB (if applicable) must be submitted for claims to be considered for accident medical expense benefits.

5. Mail the Notification of Injury form, along with any other applicable correspondence to our office. Do not leave this form with the school, coach, hospital, physician, etc. Our address is AIG, Personal Accident Claims Department, P.O. Box 25987, Shawnee Mission, KS 66225. If you need further assistance, feel free to contact Customer Service at 1-800-551-0824 (phone) / 1-866-893-8574 (fax)/ AHClaims@aig.com (email). We will be happy to assist you.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.