

**PROOF OF LOSS**

<b>AIG</b> <b>Accident and Health Claims Department</b> <b>P.O. Box 25987</b> <b>Shawnee Mission KS 66225</b>  <b>(800) 551-0824 (Telephone)</b> <b>(866) 893-8574 (Facsimile)</b> <u><b>AandH.ClaimsSubmissions@AIG.com</b></u>	<b>UNDERWRITTEN BY:</b>  <b>GROUP NAME:</b>  <b>POLICY #:</b>	National Union Fire Insurance Co  Stetson University  SRG 9139876
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**SPECIAL RISK ACCIDENT AND SICKNESS 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, IF THE 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, MAY 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 & SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER**

NAME AND/OR LOCATION OF GROUP / CLUB / SPORT / SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY)		SOCIAL SECURITY NO (IF AVAILABLE)	NAME OF SUPERVISOR
CLAIMANT'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	DATE COVERAGE BEGAN	DATE COVERAGE WILL END / HAS ENDED:

NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)

DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY:		INDICATE THE SPORT (IF APPLICABLE):	
DID ACCIDENT OCCUR WHILE / DURING:			
CLAIMANT WAS SUPERVISED <input type="checkbox"/> YES <input type="checkbox"/> NO	SPONSORED ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	PROGRAMMED HOURS <input type="checkbox"/> YES <input type="checkbox"/> NO	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 NAME (PLEASE PRINT):		DAYTIME TELEPHONE NUMBER:	
SIGNATURE OF POLICYHOLDER REPRESENTATIVE:			DATE:

**SECTION B: MUST BE COMPLETED**

HAVE OTHER HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, PLEASE PROVIDE THE FOLLOWING:			
COMPANY NAME:		GROUP NAME:		POLICY NUMBER:		RELATIONSHIP TO CLAIMANT:	
IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN:							
GUARDIAN'S SOCIAL SECURITY NUMBER:		DATE OF BIRTH:		US CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO		CLAIMANT'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF THE CLAIMANT'S GUARDIAN):							
NAME OF EMPLOYER:		ADDRESS OF EMPLOYER:				EMPLOYER TELEPHONE NO:	

I HEREBY CERTIFY THAT THE 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 PROVIDED.  YES  NO

**OPTIONAL LIMITED ASSIGNMENT**

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

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE:

DATE:



**FRAUD STATEMENTS**  
FOR USE ON ALL APPLICATIONS AND CLAIM FORMS

**ALASKA:** A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFAUD, 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 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 CIVIAL PENALTIES.

**ARKANSAS:** 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 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 DEFAUDING OR ATTEMPTING TO DEFAUD 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 DEFAUDING OR ATTEMPTING TO DEFAUD 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:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFAUD 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 DEFAUDING 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.

**FLORIDA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFAUD, 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.

**IDAHO:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**INDIANA:** A PERSON WHO KNOWINGLY AND WITH INTENT TO DEFAUD AN INSURER FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

**KENTUCKY:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFAUD 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.

**LOUISIANA:** 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.

**MAINE:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**MARYLAND:** ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**MINNESOTA:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NEW HAMPSHIRE:** ANY PERSON WHO, WITH A PURPOSE TO INJURE, DEFAUD 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.

**NEW MEXICO:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**NEW YORK:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFAUD 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 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.

**OHIO:** ANY PERSON WHO, WITH INTENT TO DEFAUD 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.

**OKLAHOMA:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**PENNSYLVANIA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFAUD 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.

**RHODE ISLAND:** 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 STATE PRISON.

**TENNESSEE:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**TEXAS:** 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.

**VIRGINIA:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFAUDING THE COMPANY, PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**WASHINGTON:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

**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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE:	DATE:
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