Welcome to the AIG Companies® family of customers.

We appreciate that you had a choice when placing your insurance and we thank you for choosing accident insurance coverages from the AIG Domestic Accident & Health Division. We realize our clients look to us not only for financial strength, but for superior service in every aspect of our performance — from our broad product portfolio and expert underwriting to our claims services.

The goal of the AIG A&H Claims Department is skillful evaluation and swift resolution of every claim. In order to deliver the level of service we strive for, we employ teams of experts in accident and health claims, and we assign dedicated specialists to cases with complex needs. Our claims specialist unit is staffed with seasoned supervisors and examiners cross-trained in all facets of claims processing. These knowledgeable professionals have the expertise to provide the right solutions and the authority to implement them. What’s more, our people are warm, patient and particularly sensitive to difficult situations.

We realize that a critical component of the claims process begins well before the claim occurs. That is, the communication of our claims process to our Insureds and our Brokers. To that end, we are pleased to present this Claims Kit. The following document delivers the detailed instructions you need to fully understand the process of filing a claim. We are committed to ensuring that you are fully aware of the various steps and forms necessary for efficient claims processing, so that your claim can be paid promptly the first time it is received in our office.

Our goal is to continuously improve our service through listening to the feedback of our customers. Please let us know how we are doing by contacting us.

Thank You,

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Claims Kit for Special Risk Coverages

How to use this Document
Please read through this entire document before submitting your claim. If you have any questions about your claim or the process, please contact us at the number below.

Included in this package are:

- All the required forms to file a claim
- Detailed instructions for filling out forms and filing your claim
- An outline of any information and/or documentation needed to process your claim
- Mailing address to send all your claims forms and required documents
- Contact information in case you have any questions along the way
- Details on what you should expect when you file a claim

Type of Insurance Coverage

- You have Global Accident Medical and Sickness Coverage. The program provides Accident and Sickness Medical Expense benefits for usual and customary charges to treat covered injuries and sicknesses, including hospital room and board.

The instructions refer by number to the claim form that you need to complete. If you are missing a form, or have any questions about the forms or claims process, please call:

The Domestic A&H Claims Department at 1-800-551-0824
Global Accident and Sickness Medical Expense Claims Procedure

Bring the following to your Doctor’s office:

- Your insurance card
- Accident & Sickness Claim Form (GLB_PRM_ASM)

If you do not have a copy of your insurance card or this claim form, please call 1-800-551-0824.

**Step 1:** Fill out **Section A** (page 1) of the Accident & Sickness Claim Form (GLB_PRM_ASM) included in this kit. This section is mandatory, and must be filled out in its entirety.

This information allows us to:

- Establish the **Date of Loss** which is the date of injury or date your symptoms first occurred. A claim record cannot be established without a Date of Loss.
- Validate your coverage
- Collect necessary information about your injury/sickness
- Obtain your current/future address
- Collect details regarding pre-existing medical treatment and treating physicians

Please read the “Assignment of Benefits” section of the claim form and check the appropriate box. Your signature is needed at the bottom of the form.

**Step 2:** Mail the original copy of Section A from the completed Accident & Sickness Claim Form (GLB_PRM_ASM) to:

**AIG Claim Services - Accident and Health Claims Department**

P.O. Box 15701, Wilmington, DE 19850-5701

Keep a copy of the completed Accident & Sickness Claim Form (GLB_PRM_ASM) for your records. Give Section B (Page 2) to your healthcare provider (see step 3).

**Step 3:** Instruct your healthcare provider to submit **ONE** of the following documents to our claims office:

- An itemized bill (Name of Claimant, showing dates of service, description and charge of each service and nature of injury/diagnosis) for services rendered. Our claim process requires the procedure/diagnosis code be provided by your healthcare provider. A second bill or past due notice does not typically contain this information and may not be substituted.

Or,

- Itemized insurance billing forms* such as * CMS/HCFA 1500 form for physicians; UB92 form for facilities)

Or,

- Completed Section B (Page 2) of the Accident & Sickness Claim Form (GLB_PRM_ASM) included in this kit.

Your healthcare provider should forward one of the above documents to:

**AIG Claim Services - Accident and Health Claims Department**

P.O. Box 15701, Wilmington, DE 19850-5701
After you have submitted your claim

You will receive an Explanation of Benefits (EOB) explaining how your claim was processed. This document contains important information about your claim, including the status; please retain it for your records. If the claim has been denied (not paid), please refer to the Remark Code section. It may be that all that is needed is additional information to move the claim forward. Please review the EOB completely and call our office at 1-800-551-0824 should you have any questions.

### Common EOB Terms and Definitions

<table>
<thead>
<tr>
<th><strong>Medical Claims</strong></th>
<th><strong>Baggage Claims</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>The name of each billing party</td>
</tr>
<tr>
<td>(doctor, hospital, radiography, office, etc.)</td>
<td>(the items on your claims list)</td>
</tr>
<tr>
<td><strong>Service</strong></td>
<td>The date of loss.</td>
</tr>
<tr>
<td>The start and end dates of any treatment.</td>
<td></td>
</tr>
<tr>
<td><strong># of SVC</strong></td>
<td>Numbers of each item claimed.</td>
</tr>
<tr>
<td>The number of treatments provided.</td>
<td></td>
</tr>
<tr>
<td><strong>Total Charged</strong></td>
<td>The value you are claiming for</td>
</tr>
<tr>
<td>Total amount billed by each provider in US dollars.</td>
<td>each item.</td>
</tr>
<tr>
<td><strong>Non-Covered</strong></td>
<td>The assessed depreciation of the</td>
</tr>
<tr>
<td>The amount in US dollars that will NOT be reimbursed based on your policy.</td>
<td>item listed.</td>
</tr>
<tr>
<td><strong>Other Headings</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Amount Considered</strong></td>
<td>%</td>
</tr>
<tr>
<td>The net amount in US dollars being considered based on your policy.</td>
<td>Normally 100% unless you have</td>
</tr>
<tr>
<td></td>
<td>exceeded the policy limit, or</td>
</tr>
<tr>
<td></td>
<td>unless some is excluded because</td>
</tr>
<tr>
<td></td>
<td>it is not Reasonable and Customary.</td>
</tr>
<tr>
<td><strong>Checks Issued – Payee Name</strong></td>
<td></td>
</tr>
<tr>
<td>Person or provider to whom reimbursement check is actually made. If this is not</td>
<td></td>
</tr>
<tr>
<td>you, your provider is being paid directly by the AIG Companies®.</td>
<td></td>
</tr>
<tr>
<td><strong>Remark Code</strong></td>
<td></td>
</tr>
<tr>
<td>A numerical code which is explained in English under</td>
<td></td>
</tr>
<tr>
<td>Description of Remark Codes.</td>
<td></td>
</tr>
<tr>
<td><strong>Reasonable &amp; Customary</strong></td>
<td></td>
</tr>
<tr>
<td>Standard industry statistics showing the prevailing charge in the same geographic area for a given procedure.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix A - Claims Forms
The following pages contain all the claims forms that have been highlighted in this kit. You will find the type of claim form and the claim form number at the top of each form for easy identification. If you have any questions, or cannot find the appropriate form please contact AIG Claims services at 1-800-551-0824.
INSTRUCTIONS:
1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.
2.) Section A must be completed by the Insured in full.
3.) One of the following must be provided:
   • Section B Fully Completed by the Attending Physician, or
   • Fully Itemized Bills showing Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
4.) This form must be signed and dated in all applicable sections.
5.) This form and all attached bills must be submitted to the address indicated above.
   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

(Please Print)

Coverage Effective Date: ______/_____/______ Coverage Termination Date: ______/_____/______ Certificate Number: __________________________ (If applicable)

Social Security #: _______—_______

1.) Name of Claimant: __________________________ Date of Birth: ______/_____/______ Sex: ☐ Male ☐ Female

2.) Current Residence Address: __________________________ __________________________

3.) Date of arrival in U.S.: ______/_____/______ Daytime phone number: (_____) _______ _______

4.) Permanent Address (In Home Country): __________________________ __________________________

5.) If injury, give date injury occurred and details of the injury/accident:

   Date 1 __________________________
   Country __________________________
   Please indicate nature of the illness and/or describe your symptoms:

6.) If Illness, advise when and where symptoms first occurred:

   Date 1 __________________________
   Country __________________________
   Please indicate nature of the illness and/or describe your symptoms:

7.) Have you been treated for this illness or injury prior to the effective date of this insurance?

   If yes, provide name and address of the treating Physician(s) and date(s) first consulted:

8.) Provide Name and Address of your Regular Physician in your Home Country:

9.) Were you taking any medications prior to the effective date of this insurance? ☐ Yes ☐ No

   If yes, please provide the following:

   Drug Name: __________________________ Drug Name: __________________________ Drug Name: __________________________
   Prescribed for: __________________________ Prescribed for: __________________________ Prescribed for: __________________________
   Physician Name: __________________________ Physician Name: __________________________ Physician Name: __________________________
   Date 1st Prescribed: __________________________ Date 1st Prescribed: __________________________ Date 1st Prescribed: __________________________

10.) Do you have other health insurance? ☐ Yes ☐ No

   If yes, please provide the name, address and policy number of the Insurance:

   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

   Optional Limited Assignment

   I hereby make a limited assignment to __________________________ (my "Assignee") of the right to receive the benefits due for those covered medical expenses incurred by me and actually paid directly to the provider of those services by my Assignee. I understand that the Company bears no responsibility or liability for the validity or effect of this assignment or for any payments made by the Company prior to receipt of satisfactory proof of payment by the Assignee. I hereby specifically release, and agree to indemnify, the Company from any and all liability incurred for any such payments made.

   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, 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 subject motor vehicle or stated claim for each such 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.

   CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE: __________________________ DATE: __________________________
**Section B**

**HEALTH INSURANCE CLAIM FORM**

**CLAIMANT INFORMATION**

1. **MEDICARE** □  **MEDICAID** □  **CHAMPUS** □  **CHAMPVA GROUP HEALTH PLAN** □  **FECA BLK LUNG** □

2. **PATIENT's NAME** (First Name, Middle Initial, Last Name): ____________________________

3. **DATE OF BIRTH**
   - MM: ________
   - DD: ________
   - YY: ________

4. **INSURED's NAME** (First Name, Middle Initial, Last Name): ____________________________

5. **PATIENT's ADDRESS** (No., Street): ____________________________

6. **PATIENT's STATUS**: Single □  Married □  Other □

7. **INSURED's ADDRESS** (No., Street): ____________________________

8. **PATIENT's RELATIONSHIP TO INSURED**
   - SELF □
   - SPOUSE □
   - CHILD □
   - OTHER □ (Specify)

9. **PATIENT's DATE OF BIRTH**
   - MM: ________
   - DD: ________
   - YY: ________

10. **INSURED's DATE OF BIRTH**
    - MM: ________
    - DD: ________
    - YY: ________

11. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

12. **INSURED's OR AUTHORIZED PERSON'S SIGNATURE**.

13. **INSURED's OR AUTHORIZED PERSON'S SIGNATURE**.

14. **DATE OF CURRENT ILLNESS**
    - YY: ________
    - DD: ________

15. **IF PATIENT HAD SAME OR SIMILAR ILLNESS**
    - YY: ________
    - DD: ________

16. **DATE Patient Unable To Work in Current Occupation**
    - YY: ________
    - DD: ________

17. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

18. **Hospitalization Dates Related to Current Services**
    - YY: ________
    - DD: ________

19. **RESERVED FOR LOCAL USE**

20. **OUTSIDE LAB?** □

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

22. **MEDICAID RESUBMISSION CODE** □

23. **PRIOR AUTHORIZATION NUMBER**

24. **DATE(S) OF SERVICE FROM**
    - MM/DD/YY: ________

25. **FEDERAL TAX I.D. NUMBER**

26. **PATIENT's ACCOUNT NO.**

27. **ACCEPT ASSIGNMENT?** □

28. **TOTAL CHARGE**

29. **AMOUNT PAID**

30. **BALANCE DUE**

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS**

32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED**

33. **PHYSICIAN's OR SUPPLIER's NAME, ADDRESS, ZIP CODE & TELEPHONE #**

**GLOBAL/rev 1.0, 8/2002**