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 ______________

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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: ______________________

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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? ______________________

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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.)

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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.