Insurance Company of the State of Pennsylvania
AIG Claim Services
A&H Claims Department
P. O. Box 15701
Wilmington, DE 19850-5701
800-551-0824/302-761-3700

PROOF OF LOSS

NAME OF GROUP: **Diplomat LT**

POLICY NUMBER: **9110454**

ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL

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

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

Social Security #: _____-_____-_____

1.) Name of Claimant: _____ Claimant's Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female
(PLEASE PRINT)

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: _____

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

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

10.) Were you taking any medications prior to the effective date of this insurance? _____ *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:	_____

11.) 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.

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 ☐ (Medicare #) ☐ (ID) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (First Name, Middle Initial, Last Name)

3. PATIENT'S DATE OF BIRTH MM / DD / YY | SEX M ☐ F ☐

4. INSURED'S NAME (First Name, Middle Initial, Last Name)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ (SPECIFY)

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE NO. ( )

ZIP CODE | TELEPHONE NO. ( )

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

A. OTHER INSURED'S POLICY OR GROUP NUMBER

A. PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

3. PATIENT'S DATE OF BIRTH MM / DD / YY | SEX M ☐ F ☐

B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY | SEX M ☐ F ☐

B. AN AUTO ACCIDENT?
YES ☐ NO ☐

B. EMPLOYER'S NAME OR SCHOOL NAME

C. EMPLOYER'S NAME OR SCHOOL NAME

C. OTHER ACCIDENT?
YES ☐ NO ☐

C. INSURANCE PLAN NAME OR PROGRAM NAME

D. INSURANCE PLAN NAME OR PROGRAM NAME

D. RESERVED FOR LOCAL USE

D. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES ☐ NO ☐ **If yes,** return to & complete item 9 A-D

12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE.
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature _____ Date _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.
I authorize payment of medical benefits to undersigned physician or supplier for service described below.

Signature _____ Date _____

14. DATE OF CURRENT: MM / DD / YY ⟨ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE: MM / DD / YY

16.Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM: / / TO: / / MM / DD / YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO: / / MM / DD / YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1 |_____ . ___ 3 |_____ . ___

2 |_____ . ___ 4 |_____ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM/DD/YY	TO MM/DD/YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H DPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ☐ YES ☐NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office).

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

PIN# | GRP#

PLACE OF SERVICE CODES

1-(H) - INPATIENT HOSPITAL	4-(H)-PATIENT'S HOME	7-(NH) NURSING HOME	O-(OL)-OTHER LOCATIONS
2-(OH) - OUTPATIENT HOSPITAL	5- -DAYCARE FACILITY (PSY)	8-(SNF)-SKILLED NURSING FACILITY	A-(IL)-INDEPENDENT LABORATORY
3-(O) - DOCTOR'S OFFICE	6- -NIGHT CARE FACILITY(PSY)	9- -AMBULANCE	B- -OTHER