Insurance Co. of the State of Pennsylvania

AIG Claim Services **A&H Claims Department** P. O. Box 15701

Wilmington, DE 19850-5701 800-551-0824/302-661-4176

PROOF OF LOSS

NAME OF GROUP:

InterMedical

POLICY NUMBER:

9021446

ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL

INSTRUCTIONS:

- This form is to be used when filling a claim for reimbursement of Medical Expenses.
- Section A must be completed by the Insured in full.
 - 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.
- This form must be signed and dated in all applicable sections.
- This form and all attached bills must be submitted to the address indicated above.

ECTION A Coverage Effective Date			(PLEASE PI	RINT) nination Date: _	, ,		-	ertificate	Number		
Coverage Ellective Date		_'	Ouverage Terri	illiation bate				f applical			
Social Security #:							,	.,	,		
1.) Name of Claimant:			Cla	imant's Date of I	Birth:	/	_/	Sex:	□М	lale	☐ Female
2.) Current Residence Addre	ss:										
3.) Date of arrival in U.S.:	/		Daytime phone	e number: ()			_			
4.) Permanent Address (In H	ome Country)):									
5.) If injury, give date injury of	occurred and	details of t	he injury/accident:								,
6.) If Illness, advise when an Please indicate nature of							Date	·			
7.) Have you been treated for	r this illness o	or injury pr	ior to the effective of	date of this insur	ance?						
If yes, provide name and add											
Q \ Drayida Nama and Addra	on of your Do	aular Dha	sision in your Home	Country							
8.) Provide Name and Addre	ss of your Re	gular Phys	sician in your Home	e Country:							
		•			If ye	es, ple	ase provide	the follow	wing:		
9.) Were you taking any med Drug Name:		to the effe	ective date of this in Drug Name:		If ye	_ Drug	ase provide 3 Name:	the follow	wing:		
9.) Were you taking any med Drug Name: Prescribed for:		to the effe	ective date of this in Drug Name: Prescribed for:		If ye	_ Drug _ Pres	Name: scribed for:	_	wing:		
9.) Were you taking any med Drug Name: Prescribed for: Physician Name:		to the effe	ective date of this in Drug Name: Prescribed for: Physician Name:	nsurance?	If ye	_ Drug _ Pres _ Phys	Name: scribed for: sician Nam	e:	wing:		
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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, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each 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.

CL	AIMANT.	OR.	AUTHORIZED	PERSON'S	SIGNATURE:

DATE:

HEALTH INSURANCE CLAIM FORM

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CLAIMANT IN	FORMATION	NC											
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2. PATIENT'S NAME (First Name, Middle	Initial, Last Name)		3. PATIEI MM	NT'S DATE OF I	SIRTH SEX	FD	4.	INSURED'S	NAME (Fi	rst Name,	Middle Ir	nitial, Last Name)
5. PATIENT'S ADDRE	SS (No., Street)		6.	PATIENT'S RELAT	TIONSHIP TO IN			•	7. INSUR	ED'S ADDR	ESS (No.	, Street)	
			SE	LF - SPOUS	E 🗆 ÇHILI	OTHER D	(SPECIF	Y)					
CITY	· - ·	STATE		PATIENT STATUS gle	rried Oth	er 🗆			CITY		~~~		STATE
ZIP CODE	TELEPHONE NO.	1	Em	ployed 🗆 Full Ti	ime \$tudent 🛘	Part-Time Student	: D		ZIP CODE		Ţſ	ELEPHO	NE NO.
9. OTHER INSURED'S	NAME		10.	IS PATIENT'S CO	NDITION RELA	TED TO:			11. INSUR	ED'S POLI	CY GROU	IP OR FE	CA NUMBER
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Signature		Date				Signature	-00:	40 D-	P-V II	Da			45
14. DATE OF CURREN MM DD	/ IN.	NESS (First sympto IURY (Accident) OF			MAS HAD SAME DATE: MM/D		:88:		tes Patient U MM	DD/YY		rrent Occ	upation MM / DD
YY / /		EGNANCY (LMP)				<i>i i</i>		/ YY FROM /		1 1			TO: /
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SIGNED	DATE						PIN	#				 G	GRP#
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