National Union Fire Insurance Co of Pittsburgh, Pa
AIG Domestic Claims
Accident & Health Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987
800-551-0824/302-661-4176

PROOF OF LOSS

NAME OF GROUP:

POLICY NUMBER:

SPECIAL RISK ACCIDENT CLAIM FORM (BSR_EXS)

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 of claimant, if 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.

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. If you have no other insurance coverage, benefits will be paid on a Primary basis up to the policy maximum. Benefits for eligible expenses will be paid per policy terms.

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 - MUST BE COMPLETED AND 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 OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR

DATE COVERAGE BEGAN — DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
	B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
INDICATE THE SPORT (IF APPLICABLE)	C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE) — TITLE — DAYTIME TELEPHONE NUMBER ( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE — DATE

SECTION B - MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE #
	( )

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**

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 C

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)	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 ☐	CITY / STATE
ZIP CODE / TELEPHONE NO. ( )	Employed ☐ Full Time Student ☐ Part-Time Student ☐	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 ☐	A. 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 — MM / DD / YY FROM: / / TO: / /
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 — MM / DD / YY FROM: / / TO: / /
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