

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: WorldMed

POLICY NUMBER:

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

(PLEASE PRINT)

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

Social Security #: _____ - _____ - _____

1.) Name of Claimant: _____ Claimant's 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: _____

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. _____

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? _____ 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 OTHER <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (ID)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS/CHAMPVA GROUP HEALTH PLAN <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	1a. INSURED'S I.D. NUMBER
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2. PATIENT'S NAME (First Name, Middle Initial, Last Name)	3. PATIENT'S DATE OF BIRTH MM / DD / YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (First Name, Middle Initial, Last Name)
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5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY)	7. INSURED'S ADDRESS (No., Street)
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CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	CITY	STATE
ZIP CODE	TELEPHONE NO. ()	Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	ZIP CODE	TELEPHONE NO. ()

9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	11. INSURED'S POLICY GROUP OR FECA NUMBER
A. OTHER INSURED'S POLICY OR GROUP NUMBER	A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	3. PATIENT'S DATE OF BIRTH MM / DD / YY
B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY	B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	SEX M <input type="checkbox"/> F <input type="checkbox"/>
C. EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	B. EMPLOYER'S NAME OR SCHOOL NAME
D. INSURANCE PLAN NAME OR PROGRAM NAME	D. RESERVED FOR LOCAL USE	C. INSURANCE PLAN NAME OR PROGRAM NAME
		D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> 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.	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 _____	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: / /
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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: / /
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19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>
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21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1 _____ 3 _____	23. PRIOR AUTHORIZATION NUMBER
2 _____ 4 _____	

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

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
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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# _____
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PLACE OF SERVICE CODES 1-(H) - INPATIENT HOSPITAL 2-(OH) - OUTPATIENT HOSPITAL 3-(O) - DOCTOR'S OFFICE	4-(H)-PATIENT'S HOME 5- -DAYCARE FACILITY (PSY) 6- -NIGHT CARE FACILITY(PSY)	7-(NH) NURSING HOME 8-(SNF)-SKILLED NURSING FACILITY 9- -AMBULANCE	O-(OL)-OTHER LOCATIONS A-(IL)-INDEPENDENT LABORATORY B- -OTHER
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