

National Union Fire Insurance Company of Pittsburgh, Pa
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: AAA Arizona, Inc.
POLICY NUMBER: SRG 9110428

ACCIDENT CLAIM FORM

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.

PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

SECTION A

(PLEASE PRINT)

- 1.) Name of Claimant: _____ Claimant's Date of Birth: ____/____/____ Sex: Male Female
- 2.) Address: _____
- 3.) AAA Membership Number: _____ Daytime phone number: () _____
- 4.) Date Coverage Began: _____
- 5.) Please give DATE injury occurred and DETAILS of the injury/accident: _____

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: _____