

Please print or type. Incomplete forms will be returned.
 SEND COMPLETED FORM & DOCUMENTS TO:



Underwritten by:
 American International Group, Inc.



NAHGA Claim Services
 PO Box 189
 Bridgton, Maine 04009
 (800) 952-4320
 (207) 647-4569 Fax

ACCIDENTAL DEATH CLAIM FORM

Please submit this completed form with a copy of the death certificate, police reports and any newspaper clippings that exist regarding for this case.

If this form is not completed in FULL, this claim can not be processed and will be returned.

PART 1: DECEASED INFORMATION

(1) School/Organization/Group Name		(2) Policy Number	
(3) Deceased - Last Name, First Name, MI		(4) Other Names the Deceased May Have Been Known	
(5) Last Address		(6) City, State, Zip	
(7) Birthdate	(8) Male <input type="checkbox"/> Female <input type="checkbox"/>	(9) Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/>	

PART 2: ACCIDENT DETAILS

(10) Date of Accident	(11) Date of Death	(12) Time & Address where occurred?	
(13) Details of Accident			(14) Was this a motor vehicle accident? Yes <input type="checkbox"/> No <input type="checkbox"/>
(15) If Motor Vehicle Accident, was decedent: Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Other <input type="checkbox"/>		(16) Type of Vehicle _____ Name of Driver _____	
(17) Police Dept/Fire Dept/EMT Involved: _____		(18) Where was decedent medical treated after accident? _____	
(19) Was the incident Homicide? Yes <input type="checkbox"/> No <input type="checkbox"/>		(20) Was the incident Suicide? Yes <input type="checkbox"/> No <input type="checkbox"/>	
(21) Witnesses? (Please give names, address and phone numbers) _____			

PART 3: CLAIMANT INFORMATION

(1) Your Last Name	(2) Your First Name	(3) Your Date of Birth	(4) Your SSN
(5) Your Mailing Address		(6) City, State, Zip	
(7) Day Telephone	(8) Evening Telephone	(9) Other Phone (i.e. Cellular)	
(10) Your Relationship to the Insured/Decedent? Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> _____			

PART 4: AUTHORIZATIONS

Your Signature: I agree to cooperate with the Company in its investigation of this claim by providing assistance including, but not limited to, completing, signing and submitting any questionnaire or authorization form needed by the Company, in its sole opinion, to conduct its investigation. I understand that no insurance agent of the company is authorized to make any claim decision or any representation as to whether any claim should or will be paid.

Beneficiary/Personal Representative Signature: X _____ Date: _____

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HIPAA Authorization - Life Claims - Authorization to Obtain and Disclose Information

Decedent Name: _____ DOB: _____

I hereby authorize all of the people and organizations listed below to give NAHGA Claim Services, American General Life and Accident Insurance Company, American General Life Companies LLC (an affiliated service company), and AGLA Service Company LLC (an affiliated service company) (collectively "the Companies") and their authorized representatives, including agents and insurance support organizations (collectively, the "recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions, and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator;
- the Medical Information Bureau (MIB); and
- _____

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance company listed above is subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the NAHGA Claim Services Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: NAHGA Claim Services, PO Box 189, Bridgton, Maine 04009. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits. This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive, upon request, a copy of this authorization.

Beneficiary/Personal Representative Signature: X _____ Date: _____

Printed Name: _____ Relationship: _____

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.