

**American International Companies®  
AIG Life Insurance Company**

A&H Claims Department  
P. O. Box 15701  
Wilmington, DE 19850-5701  
800-551-0824/302-761-3700

**PROOF OF LOSS - ACCIDENTAL DEATH**

<b>NAME OF GROUP:</b>	<b>AMERICAN PAINTBALL LEAGUE (California)</b>
<b>POLICY NUMBER:</b>	<b>8064950</b>

**GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS**

In order to assure prompt processing of this claim, please forward the claim form to the Beneficiary. The Employer/Administrator must complete PART A in its entirety. Due to recent changes in tax laws, the Beneficiary will be required to complete PART B. Be certain that PART C on the reverse side is completed in full and signed by the Beneficiary.

Return this form to the above address.

In addition to the claim form, the following items are required:

- (1) A Certified Copy of the final death certificate;
- (2) Your company's enrollment benefits form and Beneficiary Designation;
- (3) Confirmation of employee's Principal Sum and current premium payment;
- (4) The Police Report, any Autopsy Report, and any newspaper clippings.
- (5) If Business Travel, a copy of employee's itinerary prior to the accident, purpose of trip, destination to and from trip, and confirmation that trip was authorized by the company.

Every question must be fully answered. We reserve the right to require or to obtain further information should it be deemed necessary. If there is more than one beneficiary, all may join in one statement, or a separate form will be furnished for each if desired.

**PART A: GROUP POLICYHOLDER/EMPLOYER INFORMATION**

GROUP POLICYHOLDER/EMPLOYER ADDRESS

DIVISION NAME AND ADDRESS			ACCIDENTAL DEATH BENEFIT IN FORCE \$	
EMPLOYEE'S NAME AND ADDRESS		DATE EMPLOYED	DATE OF BIRTH	
EFFECTIVE DATE OF COVERAGE	SOCIAL SECURITY NUMBER	DATE OF DEATH	OCCUPATION	
TERMINATION DATE OF COVERAGE	INSURANCE CLASS	SALARY ON DATE LAST WORKED (HRLY/WKLY/MTHLY/ANNLy)	DATE PREMIUM PAID TO	
DATE LAST WORKED	STATUS ON DATE LAST WORKED:			
	<input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> PREMIUM WAIVER FOR DISABILITY <input type="checkbox"/> APPROVED LEAVE OF ABSENCE (EXPLAIN) <input type="checkbox"/> OTHER			
EMPLOYEE WAS:	<input type="checkbox"/> HOURLY <input type="checkbox"/> SALARIED <input type="checkbox"/> COMMISSIONED <input type="checkbox"/> OTHER (EXPLAIN)			

**If Claim is For Dependent, Provide the Following:**

DEPENDENT'S NAME AND ADDRESS	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT
DEPENDENT'S OCCUPATION	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER	

**GROUP POLICYHOLDER/EMPLOYER SIGNATURE**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE SIGNED	PLACE (CITY, STATE)	PHONE NUMBER
GROUP POLICYHOLDER/EMPLOYER		BY (THEIR AUTHORIZED REPRESENTATIVE)

**PART B: IMPORTANT TAX INFORMATION**

**To Be Completed by Beneficiary**

Social Security Number/ Tax ID Number	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											Please Print or Type Name of Beneficiary

Under penalties of perjury, I certify: (1) that the Social Security/Tax ID Number shown above is my correct Social Security or Taxpayer Identification Number.

**Be Certain Part C on the Reverse Side is Completed**

**PART C: BENEFICIARY INFORMATION**

In order to assure prompt processing, please be certain the authorization below is signed by the beneficiary. The completed and signed claim form along with the Certified Death Certificate, Police Report, Autopsy Report, and any newspaper clippings should be returned to the Employer/Administrator.

NAME OF BENEFICIARY	RELATIONSHIP TO DECEDENT	BENEFICIARY'S DATE OF BIRTH

**NOTE:** If any designated beneficiary is deceased, submit that beneficiary's certified Death Certificate. If the beneficiary is the Deceased's estate, furnish certified letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If the beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and minor's social security number.

WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR)	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER)
WHAT WAS CAUSE OF DEATH?	DATE OF DEATH (MO., DAY, YEAR) ATTACH COPY OF DEATH CERTIFICATE.	
WHEN DID SYMPTOMS OF CAUSE OF DEATH FIRST APPEAR?		

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED FOR THE INJURIES CAUSING DEATH.		
NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST ALL PHYSICIANS AND SURGEONS WHO ATTENDED DECEASED DURING THE LAST FIVE YEARS (STATE AILMENTS INVOLVED).		
NAME	ADDRESS	AILMENT
NAME	ADDRESS	AILMENT

LIST ALL WITNESSES TO ACCIDENT.		
NAME & ADDRESS	NAME & ADDRESS	NAME & ADDRESS

LIST OTHER COVERAGES AND AMOUNTS OF INSURANCE IN FORCE ON DECEASED'S LIFE.			
NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE
NAME OF COMPANY	POLICY NUMBER	EFFECTIVE DATE	AMOUNT OF INSURANCE

HAVE DIVORCE PROCEEDINGS EVER BEEN INSTITUTED BY OR AGAINST THE DECEASED? IF YES, INDICATE WHEN, WHERE AND THE OUTCOME.

HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

**AUTHORIZATION**

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.

**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.**

SIGNATURE OF BENEFICIARY, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN	DATE SIGNED (MONTH, DAY, YEAR)
ADDRESS OF NEXT OF KIN (NO., STREET, CITY, STATE)	BUSINESS PHONE NUMBER (       )       )
	HOME PHONE NUMBER (       )       )