

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

NAME OF GROUP:	AMERICAN PAINTBALL LEAGUE (Florida)
POLICY NUMBER:	8064950

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM**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.) If claimant is treated in the hospital, please attach an itemized hospital bill.
- 4.) If claimant is treated by a doctor, have the doctor complete the Physician's Statement or attach an itemized bill.
- 5.) 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.
- 6.) Please mail completed form and bills to above address.

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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SECTION A

LOCATION OF GROUP POLICYHOLDER
 Johnson City, TN

CLAIMANT'S FULL NAME	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR
DATE COVERAGE BEGAN		DATE COVERAGE WILL END/HAS ENDED	
NATURE OF INJURY OR ILLNESS. (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:		
INDICATE THE SPORT (IF APPLICABLE)	A. WHILE CLAIMANT WAS SUPERVISED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	B. DURING SPONSORED ACTIVITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	C. DURING PROGRAMMED HOURS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	<input type="checkbox"/> YES	<input type="checkbox"/> 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

NAME OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	DAYTIME TELEPHONE NO. ()
ADDRESS OF CLAIMANT (PARENT OR GUARDIAN IF A MINOR)	

OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF INSURED, NAME AND ADDRESS OF INSURANCE COMPANY, NAME OF EMPLOYER AND POLICY NUMBER.)
 YES _____ NO _____

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

SIGNATURE (CLAIMANT OR PARENT, IF CLAIMANT IS A MINOR) _____ DATE _____

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.

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
---	---	---	---	---------------------------

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)
---	--	--	---

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)
------------------------------------	---	------------------------------------

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"/> D. RESERVED FOR LOCAL USE	11. INSURED'S POLICY GROUP OR FECA NUMBER
A. OTHER INSURED'S POLICY OR GROUP NUMBER		3. PATIENT'S DATE OF BIRTH MM / DD / YY
B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>
C. EMPLOYER'S NAME OR SCHOOL NAME		B. EMPLOYER'S NAME OR SCHOOL NAME
D. INSURANCE PLAN NAME OR PROGRAM NAME		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: / /
-----------------------------------	---	---	---

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: / /
---	---	--

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>
----------------------------	---

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 _____	
2 _____ 4 _____	

24. A		B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE FROM MM/DD/YY TO MM/DD/YY		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

25. FEDERAL TAX I.D. NUMBER SSN EIN	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 \$
--	---------------------------	--	------------------------	-----------------------	-----------------------

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.)	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 #
SIGNED _____ DATE _____		PIN# _____ GRP# _____

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	0-(OL)-OTHER LOCATIONS A-(IL)-INDEPENDENT LABORATORY B- -OTHER
---	--	--	--