AMERICAN BAR ENDOWMENT
More than 80 years of service

Group Benefits

Catastrophic Major Medical Claim Form

Administrative Office
P.O. Box 81879, Cleveland, OH 44181-1879
Tel +1 800-348-6908 Fax +1 806-731-4898
Email: EMM_claims@corebridgefinancial.com

The United States Life Insurance Company in the City of New York
New York, New York

1. Fully complete all pages of this claim form, including the HIPAA Authorization and Fraud Statement.
2. Attach fully itemized bills from your health care providers. An itemized bill contains: the patient's name; the date(s) services were rendered; a description of the services rendered; the CPT/Revenue code(s) for each service and the fee for each service; the diagnosis or ICD-10 code; and the name, address, telephone number, professional status and Federal Tax Identification number of the health care provider.
3. Attach the corresponding statements of payment or denial from all other insurance carriers, commonly known as an Explanation of Benefits.
4. Mail to the address listed above.

Name of Insured (first, middle initial, last) (Please Print)		Certificate Number	Policy Number E	
Insured's Address, Street & No.		City	State	Zip
Phone No.	Date of Birth	Male ☐ Female ☐		
Single ☐ Divorced ☐ Other ☐ Married ☐ Widowed ☐	If Married, Spouse's Name		Spouse's Date of Birth	
Patient's Name for whom claim is being made (first, middle initial, last)		Patient's Relationship to Insured	Single ☐ Married ☐	
Patient's Address, Street & No.		City	State	Zip
Patient's Sex Male ☐ Female ☐	Patient's Date of Birth	If over age 19 and attending school or college, Provide Proof of Full Time Student Status		
Nature of Sickness or Injury	Date first treated for this condition	Is condition related to employment? Yes ☐ No ☐ Is condition related to an auto accident? Yes ☐ No ☐		
If related to an injury, how, when and where did the injury occur?				
If hospitalized, give name and address of hospital		Dates of confinement		
Treating Physician's Name	Treating Physician's Telephone Number			
Treating Physician's Address, Street & No.		City	State	Zip

Please indicate by checking yes or no and providing the policy number if you and/or the patient have coverage under any of the following plans.
Medicare - Yes ☐ No ☐ Policy # _____ GHI - Yes ☐ No ☐ Policy # _____ Aetna - Yes ☐ No ☐ Policy # _____ United HealthCare - Yes ☐ No ☐ Policy # _____ BlueCross - Yes ☐ No ☐ Policy # _____ AARP - Yes ☐ No ☐ Policy # _____ Please list all other coverages you and/or the patient may have.

Policy # _____ Insurance Co. Name & Address _____ Policy # _____
Insurance Co. Name & Address _____ Policy # _____ Insurance Co. Name & Address _____

Signature of Insured _____ Date _____

Fraud Statement
Administrative Office
The United States Life Insurance Company in the City of New York
New York, New York
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FRAUD WARNING

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:
Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.
Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.
Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: 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.
California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding and attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provided false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware, Idaho, Indiana, Oklahoma: WARNING – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia, Maine, Tennessee, Virginia, Washington: WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky: 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.
Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Pennsylvania: 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.
Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years.
New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Insured

Date

The United States Life Insurance Company in the City of New York
New York, New York

HIPAA Authorization
Administrative Office
P.O. Box 81879, Cleveland, OH 44181-1879
Tel +1 800-348-6908 Fax +1 806-731-4898

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number (Insert last 4 digits of SS# only)

I hereby authorize all of the people and organizations listed below to give The United States Life Insurance Company in the City of New York and the American General Life Companies LLC, (an affiliated service company), collectively the "Companies", and their authorized representatives, including its administrator, Marsh US Consumer as well as other 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; 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 or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other Companies 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; and
- the Medical Information Bureau (MIB).

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 companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Companies Notice of Health Information 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: Group Benefits, P.O. Box 88179, Cleveland, OH 44181-1879. 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 a copy of this authorization.

Signature of Claimant or Claimant's Personal Representative

Date

Description of Authority of Personal Representative (if applicable)