AIG Accident and Health Claims
P. O. Box 25987
Shawnee Mission, KS 66225
800-551-0824 (Telephone)
866-831-3636 (Facsimile)
AHClaims@AIG.com (Email)

PROOF OF LOSS - CORPORATE ACCIDENT - MEDICAL EXPENSE

NAME OF GROUP: NVIDA Corporation

POLICY NUMBER: GTP 0009140823

GROUP POLICYHOLDER/EMPLOYER INSTRUCTIONS

In order to assure prompt processing of this claim, please complete PART A and PART B and forward the claim form to the Claimant. The Employer/Administrator must complete PART A in its entirety. Be certain that PART B is completed in full and signed by the Claimant.

Return this form to the above address.

In addition to the claim form, the following items are required:
(1) Your company's enrollment benefits form;
(2) Confirmation of employee's Principal Sum and current premium payment;
(3) The Police Report and any newspaper clippings.
(4) 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.
(5) If claimant is treated in the hospitalor by a doctor, please attach an itemized hospital bill.
(6) 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.

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			MEDICAL BENEFIT IN FORCE $
DIVISION NAME AND ADDRESS		Do you have a Social Security Number ☐Yes ☐No (if yes please provide)	Social Security Number
EMPLOYEE'S NAME AND ADDRESS		DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE
DATE EMPLOYED	EFFECTIVE DATE OF COVERAGE	DATE OF ACCIDENT	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: ☐ ACTIVE ☐ RETIRED ☐ PREMIUM WAIVER FOR DISABILITY ☐ APPROVED LEAVE OF ABSENCE (EXPLAIN) ☐ OTHER

EMPLOYEE IS: ☐ HOURLY ☐ SALARIED ☐ COMMISSIONED ☐ OTHER (EXPLAIN)

If Claim is For Dependent, Provide the Following:

DEPENDENT'S NAME AND ADDRESS	☐ MALE ☐ FEMALE	SOCIAL SECURITY NUMBER	RELATIONSHIP	AMOUNT OF BENEFIT
DEPENDENT'S OCCUPATION	U. S. CITIZEN ☐ YES ☐ NO	DEPENDENT'S DATE OF BIRTH	NAME AND ADDRESS OF EMPLOYER	

Please Be Certain the Next Page is Completed

PART A (Cont.): 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: Insured Information

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

WHEN DID ACCIDENT HAPPEN? (MONTH, DAY, YEAR)	TIME ☐ A.M. ☐ P.M.	WHERE DID ACCIDENT HAPPEN? (IF CITY OR TOWN, SHOW STREET NUMBER)

WHEN DID SYMPTOMS FIRST APPEAR?

HOW DID ACCIDENT HAPPEN? (DESCRIBE FULLY)

SUPERVISOR'S NAME AND TELEPHONE NUMBER:

I 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.

California :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.

Rhode Island : 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.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company 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 value of the subject motor vehicle or stated claim for each violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.

For claimants not residing in California, Rhode Island, 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.

I authorize payment of medical benefits to the physician or supplier for service performed. ☐ Yes ☐ No

SIGNATURE OF CLAIMANT	DATE SIGNED (MONTH, DAY, YEAR)