

## SPECIFIED CRITICAL ILLNESS CLAIM FORM INSTRUCTIONS



DATE OF BIRTH

## **Specified Critical Illness Claim**

Please complete the Policyholder/Claimant Information section and attach a copy of the policyholder/s birth certificate. If additional space is needed to include all names of doctors or hospitals in attendance, please attach a separate piece of paper for your additional listings. Please read the authorization section and sign in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. Failure to sign the authorization will delay the processing of your claim. Have your attending physician complete the section on the reverse side of the form that corresponds to the specified critical illness for which the claim is being made.

## **Health Screening Claim**

POLICYHOLDERÍS NAME

If you are filing for the health screening benefit, complete the first three lines of the Policyholder/Claimant Information section and the Health Screening Information section. Attach documentation indicating the type of test performed, the date the test was performed, and the charges incurred.

POLICYHOLDER/CLAIMANT INFORMATION

POLICY/CERTIFICATE NO.

Send all claims to: American General Assurance Company

Specified Critical Illness Claims Processing Unit

Post Office Box 7308

Columbia, South Carolina 29202

(800) 308-6457

POLICYHOLDERIS ADDRESS						POLICYHOLDERIS NO.	TELEPHONE			
CLAIMANTÍS NAME		RELATIONSHIP TO THE CLAIMANTIS DA		ATE OF BIRTH		CLAIMANTIS DATE OF DEATH (IF APPLICABLE)				
WHAT IS THE SPECIFIED CRITICAL ILLNESS FOR WHICH THE CLAIM IS BEING MADE?		REST DIAGNOSED? CONDITION:			R HAD THE SAME OR A SIMILAR					
LIST THE NAME, ADDRESS, AND TELEPHONE NUMBER FOR ALL ATTENDING PHYSICIANS FOR THE SPECIFIED CRITICAL ILLNESS (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)										
IF HOSPITALIZED, PROVIDE THE NAME AND ADDRESS OF THE TREATING FACILITY (PLEASE ATTACH A SEPARATE LIST IF ADDITIONAL SPACE IS NEEDED)										
WHICH HEALTH SCREENING TEST DID YOU HAVE PE		HEALTH SCREENING INFO	RMATION			20.40.04				
□ STRESS TEST ON A BICYCLE OR TREADMILL □ SERUM CHOLESTEROL TEST (HDL AND LDL) □ CA 15-3 (BLOOD TEST FOR BREAST CANCER) □ CHEST X-RAY □ HEMOCULT STOOL ANALYSIS □ PSA (BLOOD TEST FOR PROSTATE CANCER)		IMED. FASTING BLOOD GLUCOSE TES BONE MARROW TESTING CA 125 (BLOOD TEST FOR OVA COLONOSCOPY THERMOGRAPHY SERUM PROTIEN ELECTROPHO	RIAN CANCER)		BREAST CEA (BLC	EST FOR TRIGLYCE ULTRASOUND DOD TEST FOR COLE SIGMOIDOSCOPY				
DATE THE HEALTH SCREENING TEST WAS PERFORE	MED									
AUTHORIZATION  Several states require that the following statement appear on the claim forms:  Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.										
I have checked the answers given by myself and they are insurance or reinsuring company, consumer reporting age or mental condition and/or treatment and any non-medica information. This Information is to include, but is not limit or prescriptions, testing and/or treatment of HIV (AIDS vir the information obtained by use of the Authorization will be information obtained will not be released by American Ge organizations performing business or legal services in cor request to receive a copy of this Authorization. I AGREE be valid for the duration of my claim.	ency, or all informed to infor	or employer having information available. The matter of me, to give to American information pertaining to diagnosis ad/or other sexually transmitted dis d by American General Assurance Assurance Company to any persolon with my claim, or as may otherwork.	illable as to diagnos General Assurance care or treatment fe eases, including cas Company to determ n or organization EX ise lawfully required	Companion psychological companion psychological companion psychological companion comp	ment and property or its legalerized isolation in the control of t	rognosis with respect all representative, any ler, drug or alcohol ab cal antecedents. I UN nefits under an existin companies, or other authorize. I KNOW the	to any physical and all such use, treatment IDERSTAND g policy. Any persons or nat I may			
Policyholderís Signature:		Date: Claimantís S	ignature:			Date:				

## SPECIFIED CRITICAL ILLNESS CLAIM FORM

PATIENTIS NAME	ATTENDIN	IG PHYSICIANIS STATE	DATE OF BIRTH		DATE OF DEATH (IF APPLICABLE)							
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIV TREATMENT FOR THIS OR A SIN	G COMPLICATION	S)									
	☐ YES, WHEN	<u>.</u>										
	-	ER/CARCINOMA IN SIT	U									
DATE OF DIAGNOSIS (THE DATE T	HE PATHOLOGICAL SPECIMEN(S)		WAS THE CANCER/CAI	RCINOMA IN SITU								
WHICH CANCER OR CARCINOMA	IN SITU WERE DIAGNOSED)		☐ PATHOLOGICALLY DIAGNOSED, OR	∕ □ CL	INICALLY DIAGNOSED							
IF THE CANCER/CARCINOMA IN SI	TU WAS PATHOLOGICALLY DIAGN	OSED, ATTACH A COPY OF		RT. IF THE CANO	CER/CARCINOMA IN							
SITU WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.												
DOES THE PATIENTIS CONDITION	MYOCARDIAI MEET ALL OF THE FOLLOWING CF	L INFARCTION (HEART RITERIA:	ATTACK)									
ARE NEW AND SERIAL ELEC     ATTACH A COPY OF THE EKG	?	s 🗆 NO										
WERE CARDIAC ENZYMES E     CREATINE PHYSPHOKINASE	ORT.	s 🗆 NO										
3. DID DIAGNOSTIC STUDIES C ARTERIES? ATTACH COPIES	NARY 🗆 YE	s 🗆 NO										
4. DID THE PATIENT HAVE CHE	☐ YE	s 🗆 NO										
DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)												
	N HEART SURGERY TO CORRECT		SE OF ONE OR MORE	□ YE	S D NO							
	ASS GRAFTS? IF SO, ATTACH A CC EED FOR CORONARY ARTERY BYF		HE PATIENT FIRST TREAT	ED FOR SIGNS C	R SYMPTOMS OF							
	WA IS		-									
DID THE DATIENT LINDERCO SUDA	WAJC GERY TO RECEIVE A HUMAN HEAR	OR ORGAN TRANSPLAN		A   D   VE	0 10 10							
COPY OF THE OPERATIVE REPOR		II, LUNG, KIDNET, OR PAN	CREAS? IF SO, ATTACH	A D YE	S D NO							
WHAT CONDITION CAUSED THE NEED FOR THE MAJOR ORGAN TRANSPLANT?  WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?												
		STROKE										
CEREBRAL ARTERY? STROKE DO ISCHEMIA, HEAD INJURY, OR CHR	E, MEANING APOPLEXY, SECONDA DES NOT INCLUDE TRANSIENT ISCH CONIC CEREBROVASCULAR INSUFI	HEMIC ATTACKS AND ATTA FICIENCY.	ACKS OF VERTERBROBAS		S D NO							
DID THE PATIENTIS STROKE PROI DAYS FOLLOWING DIAGNOSIS? F FORM OF EITHER A COMPUTED A REPORT.		S D NO										
DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?												
		RENAL FAILURE										
DOES THE PATIENT HAVE END ST	AGE RENAL FAILURE PRESENTING		BLE FAILURE TO FUNCTI	ON D YE	s 🗆 no							
OF BOTH KIDNEYS?	LURE NECESSITATE REGULAR REI	·		O YE								
DIALYSIS (AT LEAST WEEKLY) OR DATE OF DIAGNOSIS (THE DATE A												
WHAT IS THE CAUSE FOR THE PA	TIENTIC DENAI DICEACES	I WHEN WAS T	HE PATIENT FIRST TREAT	ED EOD SIONS O	AD SYMPTOMS OF							
WHAT IS THE GAUGE FOR THE FA	ED FOR SIGNS C	N STWIFTOWIS OF										
ATTENDING PHYSICIANIS SIGNATURE												
I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.												
NAME (ATTENDING PHYSICIAN) PI		DEGREE	EPHONE NUMBE	NE NUMBER								
ADDRESS		CITY	STA	ΤΕ	ZIPCODE							
SIGNATURE		DATE	MEI	DICAL ID#	I							