



SPECIFIED CRITICAL ILLNESS CLAIM FORM



INSTRUCTIONS

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

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.

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

Form with sections: POLICYHOLDER/CLAIMANT INFORMATION, HEALTH SCREENING INFORMATION, AUTHORIZATION. Includes fields for name, address, relationship, illness details, and screening tests.

SPECIFIED CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT				
PATIENT'S NAME		DATE OF BIRTH	DATE OF DEATH (IF APPLICABLE)	
WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR?	HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILAR CONDITION? <input type="checkbox"/> YES, WHEN _____ <input type="checkbox"/> NO	DIAGNOSIS (INCLUDING COMPLICATIONS)		
CANCER/CARCINOMA IN SITU				
DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ON WHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED)		WAS THE CANCER/CARCINOMA IN SITU <input type="checkbox"/> PATHOLOGICALLY <input type="checkbox"/> CLINICALLY DIAGNOSED DIAGNOSED, OR		
IF THE CANCER/CARCINOMA IN SITU WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/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.				
MYOCARDIAL INFARCTION (HEART ATTACK)				
DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:				
1. ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKG'S AND REPORTS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
2. WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHOSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT.	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
3. DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES? ATTACH COPIES OF ANY APPLICABLE REPORTS.	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
4. DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
DATE OF DIAGNOSIS (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)				
CORONARY ARTERY BYPASS SURGERY				
DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARY ARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
WHAT CONDITION CAUSED THE NEED FOR CORONARY ARTERY BYPASS SURGERY?	WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?			
MAJOR ORGAN TRANSPLANT				
DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, LUNG, KIDNEY, OR PANCREAS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> 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				
DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTEBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY.		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
DID THE PATIENT'S STROKE PRODUCE PERMANENT CLINICAL NEUROLOGICAL SEQUELA PERSISTING FOR MORE THAN 30 DAYS FOLLOWING DIAGNOSIS? PLEASE PROVIDE EVIDENCE TO SUPPORT PERMANENT NEUROLOGICAL DAMAGE IN THE FORM OF EITHER A COMPUTED AXIAL TOMOGRAPHY (CAT SCAN) REPORT OR MAGNETIC RESONANCE IMAGING (MRI) REPORT.		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?)				
RENAL FAILURE				
DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS)				
WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE?		WHEN WAS THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF THIS CONDITION?		
ATTENDING PHYSICIAN'S 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) PLEASE PRINT		DEGREE	TELEPHONE NUMBER	
ADDRESS		CITY	STATE ZIP CODE	
SIGNATURE		DATE	MEDICAL ID#	