



Accident/Injury Claim Form

Claims Department
 17900 N. Laurel Park Dr.
 Livonia MI 48152-3992
 (800) 624-1662

Certificate/ Policy number

Claim #

<p>Instructions</p> <p>Complete all parts of this claim form as required.</p> <p>Additional documentation may be requested as necessary for the evaluation of this claim.</p> <p>If you have any questions or need assistance, please call our Claims Department toll-free at 1-800-624-1662 and follow the prompts for Claims.</p> <p>Acceptance of this form is not an admission of liability under the certificate/policy.</p>

<p><i>Representative/Attorney's Authorization</i></p> <p>If a representative/attorney will be handling this claim on your behalf, please complete this section.</p>	
<p>I give authorization to my representative/attorney to represent me in all manners regarding this claim.</p>	
<p>If benefits are approved:</p> <p><input type="checkbox"/> The check is to be made payable in my name, however, mailed to my attorney.</p> <p><input type="checkbox"/> The check is to be mailed directly to me.</p>	
<p>Claimant's Signature: _____</p>	<p>Date _____</p>
<p>Representative/Attorney's Name: _____</p>	<p>Representative/Attorney's phone number: _____</p>
<p>Representative/Attorney's Address: _____</p>	<p>City: _____ State: _____ Zip Code: _____</p>

<p><i>CLAIMANT'S STATEMENT</i></p> <p>PLEASE TYPE OR PRINT</p>	
-----------------------------------------------------------------------	--

<p>1a. Insured's Name: _____</p>	<p>1b. Also known as: _____</p>		
<p>2. Date of Birth: _____</p>	<p>3. <input type="checkbox"/> Female <input type="checkbox"/> Male</p>		
<p>4. What injury was suffered? _____</p>	<p>5. Initial onset of injury Date: _____ Time: _____</p>		
<p>6. Describe fully how and where the accident occurred: _____ _____</p>			
<p>7a. Date doctor was first seen: _____</p>	<p>7b. Doctor Name, Address & Phone Number: _____ _____</p>		
<p>8a. Hospital emergency room treatment date: _____</p>	<p>8b. Hospital Name & Address: _____ _____</p>		
<p>9a. Hospital confinement? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>9b. Date Admitted: _____</p>	<p>9c. Date Discharged: _____</p>	<p>9d. Hospital Name & Address, if different than 7b: _____ _____</p>
<p>10a. Extended Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>10b. Date Admitted: _____</p>	<p>10c. Date Discharged: _____</p>	<p>10d. Facility Name & Address: _____ _____</p>

CLAIMANT'S STATEMENT
(Continued)

If your accident was auto related, please complete questions 17 through 21.

17. Were the police at the scene of the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
18a. If yes, give the name of the Department or authority who responded to the accident:	18b. Name of Official:
	Address:
	Telephone:
19a. Who is your Auto Insurance Carrier?	19b. Name of Claim Representative:
	Address:
19c. Claim/Policy#:	Telephone:
	20. Give the year, make and model of the vehicle:
21. Was the vehicle damaged? <input type="checkbox"/> Yes <input type="checkbox"/> No	

If this claim is for dependent benefits, please complete questions 11 through 16c.

11. Name of Policyowner:		12. Policy-owner's Telephone (with area code):		13. Relationship to patient:	
14. Policyowner Address:			City:		State:
15. <input type="checkbox"/> Full time student <input type="checkbox"/> Part time student		16a. Name of School:		16b. Telephone (with area code):	
16c. Address:			City:		State:
					Zip:

I declare that the preceding statements are true and complete, and that, to the best of my knowledge and belief, I have withheld no material facts from the company. I have read and initialed the applicable fraud warning attached in this form

Date:	Claimant/Representative Signature:
Address:	
City/State/Zip:	
Telephone:	

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

The purpose of this disclosure is to evaluate my claim for benefits. I understand that furnishing of forms by the AAA Life Insurance Company ("Company") does not constitute an admission of liability. I hereby authorize any licensed physician, medical practitioner, hospital (including veterans' hospitals), clinic, pharmacy, pharmacy benefit manager or other medical-related facility, insurance company, the Medical Information Bureau ("MIB") or other organization that has any records or knowledge of medical or prescription history about me/the insured to give any such information to the Company, its reinsurer(s) or any agency employed by the Company to collect and transmit such information. Such information is to include, but is not limited to, any and all records and information regarding diagnosis, testing, treatment, prescriptions, and prognosis of any physical or mental condition. The Company will not use or disclose medical information for any other purposes other than stated, except as may be required by law. Such medical information may be subject to re-disclosure and may no longer be protected by federal privacy regulations. I understand I have the right to revoke this authorization in writing to the Company; however, if I do, the Company may be unable to complete the evaluation of the claim for benefits. This Authorization will remain in effect for a maximum of twelve (12) months from the date of my signature below. A photocopy of this authorization will be treated in the same manner as the original.

Date _____ Claimant's/Representative Signature _____

FRAUD WARNINGS:

Please read the fraud warning for the state of issue of the contract and write your initials in the box.

- The state is not listed below:** Any person, who with intent to defraud, or knowing that he/she is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- 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 or civil penalties.
- Arkansas:** 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 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.
- Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or 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 provides 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:** 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:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties 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.
- Idaho:** 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.
- Indiana:** A person who knowingly, and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information commits a felony.
- 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.

**FRAUD WARNINGS:
(CONTINUED)**

- Louisiana:** 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.

- Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

- 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.

- NEW MEXICO:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

- Ohio:** Any person who, with intent to defraud or knowing that he/she 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.

- Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- 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 civil and criminal penalties.

- Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- 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.

- Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

ATTENDING PHYSICIAN'S REPORT

AAA Life Insurance Company 17900 N. Laurel Park Dr. Livonia MI 48152-3992

PLEASE TYPE OR PRINT

1. Patient's Name:		2. Date of Birth:	3. Initial onset date of injury:	
4. Type of injury:			5. Diagnosis and concurrent conditions:	
6a. What is the first treatment date for this injury? Date: _____	6b. Did you ever treat the patient prior to this injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	6c. If "YES", give the period: From _____ To _____		
7a. Was there a pre-existing condition that caused or contributed to this loss? <input type="checkbox"/> YES <input type="checkbox"/> NO				
7b. If "YES", explain:				
8a. Was the patient confined in a hospital as a resident inpatient for treatment of this illness/injury? <input type="checkbox"/> YES <input type="checkbox"/> NO				
8b. If "YES", Hospital Name:		8c. Date Admitted:		
Hospital Address:		Date Discharged:		
Hospital Phone Number:		8d. What portion was due solely to the accident? <input type="checkbox"/> All <input type="checkbox"/> None <input type="checkbox"/> _____ Days		
9a. Did the patient require medically prescribed recuperation at home or in treatment facility? <input type="checkbox"/> YES <input type="checkbox"/> NO		9b. If "YES" how many days?	9c. Facility Name:	
			Address:	
10a. At the time of the accident, was the patient intoxicated or under the influence of non-prescribed narcotics or other drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO	10b. Blood Alcohol Concentration _____	10c. Under the influence of non-prescribed narcotics or drugs Narcotic/drug type _____ Tests results _____		

11a. Was there a loss of limb(s) at or above the wrist or ankle joint(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO				
11b. Which limb(s) was severed or amputated?	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Leg
11c. Where was the point of severance or amputation?				
11d. What was the date of severance or amputation?				

13a. Was there a total and irrecoverable loss of sight? <input type="checkbox"/> YES <input type="checkbox"/> NO	
13b. Which eye(s)? <input type="checkbox"/> Left <input type="checkbox"/> Right	
13c. What was the date of the loss of sight?	

Date:	Physician's Signature:	Degree:
Tax Identification Number:	Physician's Printed Name:	
	Address:	
	Phone Number:	