

AIG Life Insurance Company

Mail Claims to
 Mass Benefits Attn: Theresa Willett
 P. O. Box 828
 Annandale, VA 22003-0828
 800-221-3083 / 703-256-7800

PROOF OF LOSS

NAME OF GROUP:	Mass Benefits Consultants
POLICY NUMBER:	8061552

TEMPORARY TOTAL DISABILITY ACCIDENT OR SICKNESS CLAIM REPORT

INSURED'S FULL NAME (PLEASE PRINT)		CERTIFICATE NO. (IF APPLICABLE)	
STREET ADDRESS		CITY	STATE ZIP
DATE OF BIRTH	HEIGHT AND WEIGHT	MARITAL STATUS	TELEPHONE ()
OCCUPATION	DUTIES	MONTHLY EARNINGS	WEEKLY EARNINGS
(1) Give full description of injury or disease from which you are now suffering. If an injury, tell when, where and how it happened.	SICKNESS <input type="checkbox"/> INJURY <input type="checkbox"/>		
(2A) Have you ever had this, or a similar condition, in the past?	Yes <input type="checkbox"/> Condition(s) _____		
(B) If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics.	No <input type="checkbox"/> Dates: _____		
(3A) Give exact date when illness began, or injury occurred.	(A) Date: _____		
(B) When did you first consult a physician for this condition?	(B) Date: _____		
(C) When did you become totally disabled (unable to work)?	(C) Date: _____		
(D) When were you able to again perform part of your occupational duties?	(D) Date: _____		
(E) When were you able to again perform all of your occupational duties?	(E) Date: _____		
(F) If still totally disabled, when do you expect your disability to terminate?	(F) Date: _____		
(4) Hospitals (Give complete names, addresses and dates of confinement.)	NAMES	ADDRESSES	FROM TO
(5A) Give names, addresses and telephone numbers of all attending physicians.	NAMES	ADDRESSES	TELEPHONE
(B) Give name, address and telephone number of usual family physician	NAMES	ADDRESS	TELEPHONE
(6) What other accident, sickness or disability insurance do you carry and what other organizations or companies have paid you indemnity for sickness or injury?	NAMES	ADDRESSES	BENEFITS
(7) What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of illness or injury and names and addresses of all treating doctors, hospitals and clinics.)	NAMES	ADDRESSES	
(8) Names, addresses and telephone numbers of employers and length of employment with each?	NAMES	ADDRESSES/TELEPHONE NUMBERS	FROM TO

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGN YOUR FULL NAME _____

DATED: _____

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.

For claimants not residing in California, 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.

SIGN YOUR FULL NAME _____

DATED: _____

PHYSICIAN'S STATEMENT ON OTHER SIDE

**ATTENDING PHYSICIAN'S STATEMENT
ACCIDENT OR SICKNESS**

PATIENT'S NAME AND ADDRESS	AGE
----------------------------	-----

(1A) Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location.)			
(B) Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain	Yes	<input type="checkbox"/> No	<input type="checkbox"/>
(2A) When did symptoms first appear or accident happen?	Date: _____/_____/_____		
(B) When did patient first consult you for this condition?	Date: _____/_____/_____		
(C) Has patient ever had the same or similar condition? If "Yes" state when and describe	Yes	<input type="checkbox"/> No	<input type="checkbox"/>
(3A) Nature of surgical or obstetrical procedure, if any (describe fully)			
(B) Charge to patient for this procedure, including post-operative care	Date performed: _____/_____/_____		
(C) If performed in hospital, give name of hospital	Outpatient <input type="checkbox"/>		Inpatient <input type="checkbox"/>
(4) Give dates of other medical (non-surgical) treatment, if any	charges:	Office Home Hospital Nursing Home Total (non-surgical)	\$ \$ \$ \$ \$
CHARGE PER CALL			
(5) What other services, if any, did you provide or prescribe patient? (Itemize, giving dates and fees)			
(6) Is patient still under your care for this condition? If "no" give date your services terminated	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date: _____/_____/_____
(7A) How long was or will patient be continuously totally disabled (unable to work)?	From: _____/_____/_____ To: _____/_____/_____		
(B) How long was or will patient be partially disabled?	From: _____/_____/_____ To: _____/_____/_____		
(C) Was house confinement necessary? If "Yes" give dates	Yes <input type="checkbox"/>	No <input type="checkbox"/>	From: _____/_____/_____ To: _____/_____/_____
(8) To your knowledge, does patient have other health insurance or health plan coverage? If "Yes" identify.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

REMARKS

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE ()
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE