INSTRUCTIONS FOR FILLING OUT A CLAIM FORM

1. The first five lines are self-explanatory.
2. Be sure to fill in the name and address of the physician, even though you may not be submitting his bill at this time.
3. Be sure to sign the claim form and fill in the date when you mail to the Company.
4. Enclose all bills and duplicates which you have pertaining to the illness or injury.
5. Mail the claim form and all bills to:

   American International Companies
   Accident & Health Claims Division
   P.O. Box 15701
   Wilmington, Delaware 19850-5701
   Telephone 1-800-551-0824; 302-761-3700

6. It is best to submit all bills for an illness or injury at the same time. However, if there is a delay in your receiving a bill or if your case will require extended or repeated treatment, file a claim as soon as possible after treatment, and send the bills along as you receive them. In this case, please indicate below that additional bills are to follow, giving details if possible.

IN NO CASE SHOULD YOU DELAY BEYOND 10 DAYS AFTER THE TERMINATION OF YOUR PROGRAM BEFORE SUBMITTING A CLAIM.

Remarks:

AMERICAN INTERNATIONAL COMPANIES

YMCA CLAIM FORM — ICCP OR WORK TRAVEL

POLICY # GLB 9019705

Name of insured .... Social Security # ....
(if applicable)

Permanent Address - Home ....

Parent or guardian if claimant is under 21 ....

Name of camp or organization ....

Address, if other than above - U.S.A. ....

Date of illness or accident ....Name of illness or injury...

If illness, have you had it before? .... When?—Dates of last medical treatment ....

If accident, how did it happen?...

....

If accident, is it job related? Yes ..... No ....If yes, is coverage available under your employer's Worker's Compensation insurance?

If no, your employer must enclose a letter of denial from his Worker's Compensation insurance company so that we may process the claim.

Check should be sent to: ☐ Doctor ☐ Hospital ☐Claimant ☐ Other

Name and address of physician: ....

If payment is to other than provider (Doctor or Hospital) attach proof of payment.

PHYSICIAN, SURGEON OR HOSPITAL AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended me or examined me, to furnish to American International Companies or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date .... Signature ....