CANCER & SPECIFIED DISEASE POLICY-
HELPFUL CLAIM TIPS

How to file your first claim:

1. Complete each section of the claim form's front page.
2. It is not required for your medical provider to complete the back page of the claim form unless you wish to assign benefits to a designated Provider. ***Warning****: If you assign benefits,* ***ALL*** *benefits will be paid directly to the designated Provider*. Otherwise, all benefits will be paid directly to the Insured.
3. Attach a copy of the **pathology report(s)** with a **positive diagnosis** of cancer or a specified disease. Be sure to attach the earliest diagnosis of cancer or specified disease to ensure proper payment of benefits.
4. Benefits are based on medical expenses for cancer or specified disease treatment. Attach itemized medical bills with your claim.
5. Mail the completed claim form and all documentation to:

   Bay Bridge Administrators, LLC
   Attn: AIG Cancer/Specified Disease Claim
   PO Box 161690
   Austin TX 78716

Faxes or photocopies of the first completed claim form will not be accepted.

Deadline to submit losses/expenses:
Within 15 months from the date the loss/expense incurred.

Itemized medical bills/statements:
Please obtain itemized medical bills from your medical providers. The medical bills should contain a breakdown of each service provided, the actual cost, and the date of service. Please also include copies of all health insurance explanation of benefit statements which correspond with your itemized medical bills.

Submitting Additional Claims:
The Insured does not need to fill out a claim form each time. On a cover sheet or posted note, please write the Insured's name and social security number. Attach it to the medical bill's first page.
Example: ***John Smith***
123-46-5678
Attn: Hartford Cancer Claim

Notification:
Any eligible benefits, denials, or request for additional information will be mailed to you within 2 weeks of receipt of your claim in our office. If you do not receive some type of notification from our office after 2 weeks, please call us to verify that we received your claim. Please be sure to make photocopies of your claims in case we do not receive one of your claims.

If you have questions or need assistance, please call us toll free at 1-800-845-7519 and ask to speak with a Claims Examiner about your cancer and specified disease policy. *8AM-5PM, Central Time, Monday-Friday*

BAY BRIDGE
ADMINISTRATORS

AIG AIG Companies℠

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA

CLAIM FORM FOR CANCER, SPECIFIED DISEASE & INTENSIVE CARE COVERAGE

FOR PROMPT CONSIDERATION, PLEASE ATTACH ITEMIZED, BILLS FROM ALL MEDICAL TREATMENT PROVIDERS, INSURANCE EXPLANATION OF BENEFIT STATEMENTS LISTING ALL PAYMENTS MADE BY YOUR HEALTH INSURANCE AND ALL PATHOLOGY REPORTS RELATING TO POSITIVE DIAGNOSIS.

☐ CANCER ☐ SPECIFIED DISEASE ☐ INTENSIVE CARE

INSURED NAME	ADDRESS (CITY, STATE, ZIP)
DATE OF BIRTH SOCIAL SECURITY NO.	TELEPHONE NO. POLICY NUMBER
PATIENT NAME	DATE OF BIRTH SOCIAL SECURITY NO.

1. Describe your illness or injury?_____

_____

How did the injury occur:_____

If an *injury*, the date of occurrence:_____ If an *illness*, the date you first noticed symptoms:

_____

2. Name and address of the *first* physician you consulted for this condition?_____

_____

3. Date, if ever, that you had similar condition before:_____

4. If you were confined to a hospital, the hospital's name and address:_____

_____

Date admitted:_____ Date discharged:_____

5. List All Physicians Consulted in the Last Five Years:

Name of Doctor Address Telephone Number Date

_____

_____

_____

***Continued on Reverse Side**

For persons NOT residing in California, New York, or Pennsylvania: Fraud Notice:
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.

For Residents of California: Fraud Warning 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.

For Residents of New York: Warning 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Pennsylvania: Warning: 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 materials thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Residents of Maryland: Warning: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, or insurance company, to furnish to National Union Fire Insurance Company of Pittsburgh, Pa., 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 identified above. I understand that this authorization is valid for two years 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.

Date_____ 20_____ Signed (patient, or parent if minor)_____

If someone other than patient executed this form and authorization, indicate reason:_____

_____

Relationship to Patient:_____

Mail To:
Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, Texas 78716