



American International Insurance Company of Puerto Rico
Claims Department (UNACO)
 #250 Muñoz Rivera Ave., Hato Rey, P.R. 00918
 P.O. Box 10181, San Juan, P. R. 00908-1181
 Tel. (787)767-6400

Accident Insurance Claim Form

To avoid unnecessary delays in the processing of this claim, please answer all questions in detail.
 Please include every invoice related to this claim.

Section I: GENERAL INFORMATION TO BE COMPLETED BY CLAIMANT

Policy #: 009-1005759

Claim #:

Insured's Name: _____ **Age:** _____ **Sex:** _____

Address: _____

Telephone: (H) _____ **(O)** _____

Employer: _____ **Occupation:** _____

Date and Time of Injury: _____ **at** _____ **:** _____ **AM / PM**

Place of Injury: _____

Injury Description: _____

Name and Address of doctor(s) that provided treatment: _____

Date of first visit: _____

Were you hospitalized for this injury: Yes No **If yes, date of hospitalization:** _____

Hospital's name: _____

Totally disabled: Yes No **Dates: from:** _____ **to:** _____

Partially disabled: Yes No **Dates: from:** _____ **to:** _____

Does the Insured have a Medical Plan? Yes No

If yes, indicate company name: _____

Policy: _____

Was the claim submitted to the Medical Plan? Yes No

I certify that the information above and invoices attached are true to my best of knowledge. I authorize all doctors, people who provided services, hospitals and other institutions to provide **American International Insurance Company of P.R.** any information, including file copies, lab exams and x-rays related to this claim. It is understood and agreed **American International Insurance Company of P.R.** reserves the right to delay the payment of this claim, if applicable, until receiving all necessary information.

In policies where an accident medical expense reimbursement benefit is provided, said medical expense reimbursement pays in excess of any other payable and collectible insurance.

Any person who knowingly and with the intent to defraud provides false information in an insurance application, or presents, assists, or makes a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same incident of damage or loss, will commit a felony and if convicted will be sentenced for each violation with a fine of no less than five thousand (\$5,000) dollars and not exceeding ten thousand (\$10,000) dollars, or be sentenced to imprisonment for a three (3) year term, or both penalties. In the event of aggravating circumstances, the term could be increased to a maximum of five (5) years; in the event of intervening extenuating circumstances it could be reduced up to a minimum of two (2) years.

I have reviewed the claim form completely. I confirm that the information provided is faithful and exact to the best of my knowledge.

Date

Insured or Claimant's Signature

Section II: DOCTOR'S REPORT

Patient's name: _____ Age: _____ Sex: _____

Diagnosis: _____

If surgery was performed, please provide details: _____

Where was the surgery performed?: _____ Date: _____

Please provide all dates on which you visited the patient at the hospital: _____

Did you order the patient's hospitalization?: Yes No If yes, date of hospitalization:

Hospital's name: _____

Based on your opinion, when did the injury take place?: _____

Is the patient still under your care?: Yes No

How long was the patient or will remain totally disabled?: _____

How long was the patient or will remain partially disabled?: _____

Patient's job obligations: _____

Doctor's name: _____

Address: _____

Phone: _____ Fax: _____

Doctor's signature: _____ License No. _____