



**AMERICAN NATIONAL INSURANCE COMPANY**

P.O. BOX 1790, GALVESTON, TEXAS 77553-1790

Toll-free: 1- 800-899-6803 or Local: 409-766-6601

**CLAIMANT INFORMATION**

1. Plan Number:	2. Name of patient:	5. Patient's Date of Birth:
3. Identification Number:	4. Name of insured:	

6. Nature of injury or illness:	7. Related to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Date of injury, or if illness, date of first symptoms:
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9. How did the accident happen?

10. Where did the accident happen?	11. Was the accident work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No
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12. Name of doctor who first treated the patient for this condition:	13. Doctor's address and phone number:	14. When was the patient first treated?
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15. Does the patient have other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Name & Address of Company:
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17. Name of insured, Plan Number and Identification Number of other medical coverage:	18. Date of Issue:
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Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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 criminal and civil penalties. CA residents - California law requires the following to appear on this form: Any person who knowingly presents a false fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison. FL residents - Florida law requires the following to appear on this form: 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. NY residents - New York law requires the following to appear on this form: 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 violation.

**THIS FORM MUST BE SIGNED BY THE PATIENT. A PARENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS A MINOR.**

19. I declare the forgoing answers and statements to be true. I hereby authorize the use or disclosure of my health information as described in this authorization. American National Insurance Company or its Agent acting on its behalf is authorized to receive and use the information to determine payment or for other health care operations. This Authorization is for the release of all Medical Records for diagnosis and treatment during the last five (5) years. Health Information may be used for Claim Processing and/or Care Management. The Authorization for Release of Health Information expires one (1) year from the date this authorization is signed.

Signature _____	Date _____	Tel. No. _____
Address _____	Street _____	City _____ State _____ Zip _____