



**Claims Department**  
 PO Box 845  
 Stevens Point, WI 54481-0047  
 Toll Free: 1-800-276-0726

AIG Claims, Inc. is a wholly owned subsidiary of AIG and provides claims administration for the Group Policy provided with your Pfizer Pledge™ Warranty Program.

**PFIZER PLEDGE™ WARRANTY PROGRAM**  
**PATIENT WARRANTY CLAIM FORM**  
 (TO BE COMPLETED BY THE PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE)

<b>CLAIM NO:</b>
------------------

**IMPORTANT NOTE:**

Please complete all sections to facilitate the processing of this form.  
 If your primary health insurance or pharmacy changed during the course of your treatments, complete a separate claim form for each.  
 Please answer all questions. An incomplete form may cause a delay in our assessment of your claim. Please either type your responses or print clearly. Coverage is provided by New Hampshire Insurance Company, an AIG Company. Coverage is subject to certain terms, conditions, and limitations, including limitations on the amount of coverage.

To enable us to process your claim expeditiously, please return the completed claim form with supporting documents as listed in the subsequent section. Please send the claim form and all correspondence to:

AIG Claims, Inc.  
 PO Box 845  
 Stevens Point, WI 54481  
 Tel: 1-800-276-0726  
 Email: PfizerPledge@AIG.com  
 Fax: 1-715-342-2490

All benefits are paid in accordance with the terms and conditions of the Group Policy. The acceptance of this claim form is NOT an admission of liability on the part of Pfizer and/or AIG Claims, Inc. Any documentary proof or report required to process this claim shall be furnished at the expense of the Patient. *This Group Policy is underwritten by New Hampshire Insurance Company, an AIG Company, and benefits are provided to you as part of Pfizer Pledge. For details about how AIG collects and uses personal information submitted via this form, please visit <https://www.aig.com/privacy-policy>.*

**Documents Required:**

1. Copy/photo of both sides of your insurance card(s) for both prescription and medical insurance
2. Copy/photo of the Explanation of Benefits (EOB) for each treatment from your Health Insurer(s)
3. Signed and completed Patient Warranty Claim Form
4. Signed and completed Patient Declarations and Authorizations Form
5. Signed and completed Physician Attestation Form from your PANZYGA-prescribing physician
6. Signed and completed Pharmacy Attestation Form from your PANZYGA-dispensing pharmacy or outpatient clinic

PATIENT INFORMATION		
Patient's Name (First, Middle, Last)		Patient Date of Birth (MM/DD/YYYY)
Patient Address (Street, City, State, ZIP)		Patient Sex (Male or Female)
Patient Primary Phone (with area code)		Patient Secondary Phone (with area code)
Patient Primary Email Address		Patient Secondary Email Address
Patient Preferred Language (if not English)		
Communications Preferences How would you like to receive claims status updates? (check all that apply)	Phone	Email
By requesting for us to communicate with you electronically, you consent to electronic delivery of notices, disclosures, documents and other communications from [AIG Claims, Inc.] via the communications method indicated above in relation to your claim, including leaving voicemails on the phone number indicated above. If applicable, you also agree to check your messages and/or email accounts and to inform [AIG Claims, Inc.] of any changes to the above information. You agree that all notices, disclosures and other communications that we provide to you electronically satisfy any legal requirements that such communications should be in writing.		

**AUTHORIZED PATIENT REPRESENTATIVE INFORMATION (IF APPLICABLE)**

Name (First, Middle, Last)	Address (Street, City, State, ZIP OR if same as Patient, write "SAME")
Primary Phone (with area code)	Primary Email Address

**HEALTH INSURANCE INFORMATION**

Has your Health Insurance for PANZYGA changed since you initiated your first dose and when you discontinued therapy? (select one) <b>If YES, complete both SECTION 1 AND SECTION 2 below.</b>	Yes	No
---	-----	----

**NOTE: In addition to the information below, please provide copy/photo of both sides of your medical and prescription insurance card(s)****Health Insurance Section 1**

Which Treatments Were Covered with This Insurance? (select all that apply)	Treatment 1	Treatment 2	Treatment 3	Treatment 4
---	-------------	-------------	-------------	-------------

**Primary Insurance (from your Primary Insurance Card)**

Primary Insurance Type (select one)	Commercial	None	
Primary Insurer Name	Primary Insurer Member Phone (with area code)		
Primary Insurer Address on Insurance Card (Street, City, State, ZIP)			
Policy Beneficiary ID #	Group ID #		
Policyholder Same as Patient? (select one)	Yes	No	Policyholder Relationship to Patient (if Patient, write "PATIENT")
Policyholder Name	Policyholder Date of Birth (MM/DD/YYYY)		

**Secondary Insurance (from your Secondary Insurance Card)**

Secondary Insurance Type (select one)	Commercial	None	
Secondary Insurer Name	Secondary Insurer Member Phone (with area code)		
Secondary Insurer Address on Insurance Card (Street, City, State, ZIP)			
Policy Beneficiary ID #	Group ID #		
Policyholder Same as Patient? (select one)	Yes	No	Policyholder Relationship to Patient (if Patient, write "PATIENT")
Policyholder Name	Policyholder Date of Birth (MM/DD/YYYY)		

**Prescription Insurance (if you have a separate Card for Prescription Insurance)**

Prescription Insurance Name	Prescription Policy ID #		
Prescription Group #	Prescription BIN #	Prescription PCN #	

**PANZYGA-PRESCRIBING PHYSICIAN INFORMATION**

Prescribing Physician Name (First, Middle, Last)	Prescribing Physician Office Phone (with area code)
Prescribing Physician Address (Street, City, State, ZIP)	

**PANZYGA-DISPENSING/INFUSING PHARMACY OR OUTPATIENT CLINIC INFORMATION**

Dispensing Pharmacy Name	Dispensing Pharmacy Phone (with area code)
Dispensing Pharmacy Address (Street, City, State, ZIP)	