AIG
Group Benefits

American General Life Insurance Company*
Houston, Texas
The United States Life Insurance Company in the City of New York
New York, New York
National Union Fire Insurance Company of Pittsburgh, Pa
New York, New York
*This company does not solicit business in New York

Administrative Office
PO Box 14294, Lexington, KY 40512
Tel +1 800-289-2266
Fax +1 855-864-0530
Email: claimsubmission@groupclaims.com

Proof of Group Death Claim
For DEPENDENTS of Employees Only

Statement of Policyholder

Name of Employee		Address of Employee	Amount of Insurance for Dependent
Group Policy Number	Social Security Number	Name and Address of Employer	Telephone Number
Duration of Employment From: Through		Last Day of Full Time Active Work for Employer	Reason for Stopping Work

Full Name of Deceased Dependent	Relationship to Employee	Dependent's Date of Birth	Social Security Number of Deceased Dependent
Is Dependent Married?	Date of Death	If Contributory Insurance, to What Date has Employee's Contribution Been Paid	
If Full Time Student, Provide Proof of Full Time Student Status			
Is Dependent Employed Full Time? ☐ Yes ☐ No		If Yes, Name and Address of Dependent's Employer	

Name of Beneficiary	Relationship	Age
Signature of Policyholder's Official Representative	Title	Current Date
Print Name of Individual Whose Signature Appears Above	Send Check To	

Claimant's Statement

Full Name of Deceased	Date of Birth	Date of Death
Cause of Death		Place of Death
When did deceased first complain of, or give indication of his last illness? Date	When did deceased first consult a physician for his illness? Date	
In What Capacity do you Claim This Insurance? (If Administrator, executor or guardian, attach copy of court order of appointment.)		
Your date of Birth	Your Social Security Number (Insert last four digits of SS# only)	

Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or correct Taxpayer ID number; and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) in this paragraph if you are subject to backup withholding and cross out item (3) in this paragraph if you are not a U.S. person (including a U.S. resident alien).

If this beneficiary is a non U.S. person an IRS form W-8 must be completed, reviewed and approved prior to any payment of funds.

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Beneficiary's Name (Print)		Beneficiary's Date of Birth		Relationship to Deceased
Address	City	State	Zip Code	Telephone Number
Beneficiary's Tax Payer ID# (SSN, ETIN, whichever is applicable):	Signature of Beneficiary, with Title, if any (U.S. person, including a U.S. resident alien):			Date

Instructions

To Avoid Unnecessary Delay In Processing Claims, Please Complete All Blank Areas And Sign Form.

The **STATEMENT OF POLICYHOLDER** should be completed and signed by an authorized representative of the group policyholder (employer, union, association, welfare fund or other organization through which the insurance was obtained).

The **CLAIMANT'S STATEMENT** should be completed and signed by the beneficiary (usually the insured employee). Anyone other than a family member may sign as witness to the beneficiary's signature.

A copy of the **ENROLLMENT FORM**, if available, and a **CERTIFIED** copy of the **DEATH CERTIFICATE** must accompany this form. Submit the claim proofs to:

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Authorization for Release of Medical Information

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DECEASED'S NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and National Union Fire Insurance Company of Pittsburgh, Pa., (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to the Deceased's health (except psychotherapy notes) and the Deceased's insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG Companies which may have provided the Deceased with life, accident, health, and/or disability insurance coverage, or to which the Deceased may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- the Deceased's employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG Companies Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: AIG-Group Benefits, P.O. Box 14294, Lexington, KY 40512. I understand that my revocation of this authorization will not affect uses and disclosure of the Deceased's health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

NAME OF CLAIMANT (PRINT)

SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE

DATE

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FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear on this form: 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.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: 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.

KENTUCKY: 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 material thereto commits a fraudulent insurance act, which is a crime.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: 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 subjects such person to criminal and civil penalties.

NEW YORK: 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.

SIGNATURE OF INSURED _____ DATE _____