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
*This company does not solicit business in New York

Claimant's Statement
Waiver of Premium Benefits
PO Box 14294, Lexington, KY 40512
Tel +1 800-289-2266 Fax +1 855-864-0530
Email: claimsubmission@groupclaims.com

THIS STATEMENT MUST BE FULLY ANSWERED BY THE INSURED OR DULY APPOINTED GUARDIAN OR CONSERVATOR. IF INSURED IS UNABLE TO ANSWER THESE QUESTIONS A BENEFICIARY OR NEAREST RELATIVE MAY DO SO.

COMPLETE, SIGN AND DATE THIS FORM, THE AUTHORIZATION FOR RELEASE OF INFORMATION AND THE FRAUD STATEMENT AND SEND ALL DOCUMENTS TO YOUR EMPLOYER.

Name of Insured			Date of Birth	
Address	City		State	Zip Code
Telephone Number	Social Security Number	Height		Weight
Name of Employer	Group Number	Telephone Number		
Address	City		State	Zip Code
Occupation/JobTitle at time of disability	Last day worked	Date of illness/injury	First day absent from work for this disability	
Medical condition preventing you from working				
Describe what limitations are preventing you from working				
Have you worked in any capacity since your disability began? ☐ Yes ☐ No If Yes, briefly describe				
Attending Physician's Name		Telephone Number		
Address	City	State	Zip Code	
First office visit	Last office visit	Next office visit		
List additional provider's name			Telephone Number	
First office visit	Last office visit	Next office visit		
Were you hospitalized? ☐ Yes ☐ No	If Yes, hospital name	Date admitted	Date discharged	
Hospital Address	City		State	Zip Code

Provide the following information concerning any other insurance you have:

Name of Insurance Company	Address	Amount of Insurance

Are you represented by a Guardian or Conservator? ☐ Yes ☐ No If Yes, provide a Copy of Appointment	
Name of Person Completing This Form (Print)	Telephone Number
Signature of Insured, Guardian or Conservator	Date

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY

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Authorization for Release of Information

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CLAIMANT'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 and The United States Life Insurance Company in the City of New York (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 my health (except psychotherapy notes) and my 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 Company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my 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 my 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 Company 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, PO Box 14294, Lexington, KY 40512. I understand that my revocation of this authorization will not affect uses and disclosure of my 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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Fraud Statement
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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 _____