AIG
Group Benefits

Accelerated Life Benefit Request
Part A

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

The United States Life Insurance Company in the City of New York
New York, New York

Please Fill out completely. Eligible employee or dependent completes and signs Part A. Attending Physician completes and signs Part B. If you have questions regarding this application please contact our customer service department at 1 800-289-2266.

In order to qualify for this benefit, I understand that I must be terminally ill with a life expectancy of _____ months or less from the date of this request. This being the case, I hereby request an Accelerated Life Benefit payment in the amount of $ _____ under the Group Life Insurance Policy, No. _____ issued to _____.
(Policyholder/Employer)

Name of Insured: _____

Address: _____

Most Recent Hospitalization Date: Month_____ Day_____ Year_____

Name and Address of Hospital: _____

_____

Name and Address of Physician: _____

Describe, in your own words, your understanding of your health (condition): _____

_____

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.

I hereby certify that the information provided above is true and correct to the best of my knowledge and belief.

Signature of Insured: _____

Date of Request: _____

Signature of Witness: _____

The receipt of this Accelerated Life Insurance Benefit may be taxable. You should seek assistance from a personal tax advisor with respect to receipt of this benefit. No representation as to any issue of taxation of this benefit are made by the company.

Signature of Insured: _____

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Physician's Statement
Part B

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New York, New York

The patient is requesting an advance life insurance benefit. Your statement is required to determine the patient's eligibility.

1. a. When did symptoms first appear or accident happen: Month _____ Day_____ Year _____
   b. Date the patient was informed of diagnosis: Month _____ Day _____ Year _____
   c. Has patient ever had the same or similar condition? ☐ Yes ☐ No
   If yes, Month_____ Day_____ Year_____
2. a. Is patient's condition terminal? ☐ Yes ☐ No
   b. If Yes, is life expectancy ____ months or less? ☐ Yes ☐ No
   c. Diagnosis (including and complications):

   _____

   _____

   d. Subjective symptoms: _____

   _____

   _____

   e. Objective findings (including current X-rays, EKGs, Laboratory Data and Clinical findings):

   _____

   _____

   f. If your opinion, has this condition affected the mental capacity of the patient? ☐ Yes ☐ No
   g. Other comments: _____

   _____

   _____

3. Dates of Treatment:
   First Visit Month_____ Day_____ Year_____
   Last Visit Month_____ Day_____ Year_____
   Frequency _____
4. Nature of Treatment (including surgery and medications prescribed, if any): _____

   _____

   _____

5. Has patient ☐ recovered? ☐ improved? ☐ remained unchanged? ☐ retrogressed?
   Is patient ☐ ambulatory? ☐ house confined? ☐ bed confined? ☐ hospital confined?
   Has patient ever been hospital confined? ☐ Yes ☐ No If Yes, Month_____ Day_____ Year_____

Print Physician's Name	Degree	Specialty	Telephone No.
Street Address	City	State or Province	Zip Code

I hereby certify that to the best of knowledge, information, and belief, the information provided herewith is true and correct.

_____
Signature of Attending Physician

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Authorization for Release of Information

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Email: claimsubmission@groupclaims.com

The United States Life Insurance Company in the City of New York
New York, New York

CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I hereby authorize all of the people and organizations listed below to 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, P.O. 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