



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

**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](mailto:claimsubmission@groupclaims.com)

**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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Email: [claimsubmission@groupclaims.com](mailto:claimsubmission@groupclaims.com)

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](mailto:claimsubmission@groupclaims.com)

CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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I hereby authorize all of the people and organizations listed below to 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, 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