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.

Packet Instructions
PO Box L, Beattyville, KY 41311
Tel +1 866-960-0772, Fax +1 888-446-2390

DISABILITY BENEFITS

This packet contains the forms necessary to apply for Disability benefits. For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your benefit administrator.

CLAIMANT INSTRUCTIONS:

1. Complete and sign your portion of the claim form.
2. Your treating physician should complete the Attending Physician's Statement. If more than one physician is treating you for your disabling condition, each should complete a form.
3. Sign and date the Authorization for Release of Information and the Fraud Statement and send them, along with the Claimant Statement, to AIG-Group Benefits at the address listed below.
4. Maintain a copy of all documents for your records.

MAIL, FAX, OR EMAIL CLAIM TO:

AIG-Group Benefits
Connecticut Claims Center
P.O. Box L
Beattyville, KY 41311
Tel +1 866-960-0772,
Fax +1 888-446-2390
Email: DMK_Disability@aig.com

WHEN YOU RETURN TO WORK

Your Disability benefits usually stop when you return to work. Be sure that you notify us immediately when you plan to, or have, returned to work to assure no overpayment occurs.

All portions of this form packet must be completed to avoid undue delay in processing the claimant's request for benefits.

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.

Claimant's Statement
PO Box L, Beattyville, KY 41311
Tel +1 866-960-0772, Fax +1 888-446-2390

TO BE COMPLETED BY THE CLAIMANT: PLEASE ANSWER ALL QUESTIONS: FAILURE TO DO SO MAY DELAY YOUR CLAIM

Patient's Name for who claim is being submitted (First, Middle, Last)				MI
Patient's Address: Street, City, State & Zip				
Social Security Number (last 4 digits only)			Date of Birth	Policy #
Gender ☐ Male ☐ Female	Height	Weight	Marital Status: ☐ Single ☐ Married ☐ Divorced	
Current Occupation/Job Title at Time of Disability		Job Location	Number of Hours Worked per Week	
Last day worked	First day absent from work for this disability	Medical condition preventing you from working		
Date of Injury	Describe Injury			
Is the condition work related? ☐ Yes ☐ No	Name of Workers' Compensation Carrier		Phone Number	
Do you expect to return to work? ☐ Yes Date ☐ No	Date returned to work full-time to original job	Date returned to work full-time at a different job or same job with modifications	Date returned to work part-time	
Were you hospitalized? ☐ Yes ☐ No	Name of Hospital		Date Admitted	Date Discharged
Hospital Address	City	State	ZIP	Phone Number
Duties of current occupation				
Present restrictions				
Attending Physician's Name			Specialty	
Address	City	State	ZIP	
Phone Number	Fax Number			
First Office Visit	Last Office Visit	Next Office Visit		

List Additional Providers Name	Phone Number	Fax Number	First Office Visit	Last Office Visit	Next Office Visit
1.					
2.					
3.					

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Signature*	**Date**

***Please sign and date the Authorization for Release of Information and the Fraud Statement and include them with this form.**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

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 any affiliated services company, (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; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth.

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

- any physician or medical practitioner;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American International Group (AIG) companies 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 insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the 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 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 L, Beattyville, KY 41311. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

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 application.

This authorization will be valid for 24 months. 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.

_____ Date_____ _____ _____

Signed of Proposed Insured or
Proposed Insured's Personal Representative

_____

Description of Authority of Personal Representative
(If applicable)

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.

DISABILITY CLAIM QUESTIONNAIRE - Other Sources of Income

With the exception of any source(s) of income reported on this form, I hereby certify by my signature that I have not and am not eligible to receive income as defined by the Plan from other sources except for my AIG-Group Benefits Disability Income. Further, I understand that should I receive income as defined by the Plan of any kind or perform work of any kind during any period AIG-Group Benefits has approved my disability claim, I must report all details to AIG-Group Benefits Claim Center immediately.

If I receive disability income benefits greater than those which should have been paid had the Company known of the additional sources of income as defined by the Plan, I understand that I will repay AIG-Group Benefits for any overpayment. Based upon its policy, AIG-Group Benefits *may have* the option to reduce, take other action or offset future disability payments in order to recover any overpayment it may be due.

I hereby certify that the answers I provide are both complete and true to the best of my knowledge and belief. I have read and signed the Fraud Statement included with this form.

Other Income and/or Benefits	**Are you receiving this income now?**	**Do you expect to receive this income in the future?**	**Date benefit started or will start**	**Amount received (per week or per month)**
Wages, Salary or Other Income From:				
• Another Employer	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• Rehabilitation Program	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
Disability Benefits From Any:				
• Group life insurance policy	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• Group Disability Insurance	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• No-fault Auto Insurance	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____

Other Income and/or Benefits	Are You receiving Income Now?	Do you expect to receive this income in the future?	Date benefit started or will start	Amount received (per week or per month)
Disability Benefits Under:				
• Workers Compensation Law	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• Occupational Disease Law or Other Similar Law	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• Veterans Administration	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• Maritime Doctrine of Maintenance, Wages and Cure	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• State Disability Benefits	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____
• Any Other Government Agency	☐ Yes ☐ No	☐ Yes ☐ No		$_____ Per_____

Print Name Claimant/Guardian/Representative	
Signature	
Date Signed	

AIG

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.

Attending Physician's Statement

PO Box L, Beattyville, KY 41311
Tel +1 866-960-0772, Fax +1 888-446-2390

TO BE COMPLETED BY THE CLAIMANT

First Name	Last Name	Date of Birth

Employer Name	Current Occupation

TO BE COMPLETED BY THE ATTENDING PHYSICIAN *Provide Copies of Medical Records, Consultative Reports and Diagnostic Tests*

Primary Diagnosis	ICD-9	Secondary Diagnosis	ICD-9

Symptoms	Height	Weight	B/P	Dominant Side ☐ Right ☐ Left

PREGNANCY *(if applicable)*

Expected date of delivery	Actual date of delivery	Type of delivery ☐ Normal ☐ C-section

Significant complications, if any (ante-partum/post-partum)

HISTORY

Patient referred by	Phone number

Date of first visit	Date(s) of subsequent visits	Date of most recent visit	Date of next visit

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If Yes, when?

Is this condition related to the patient's employment? ☐ Yes ☐ No	Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No
When did symptoms first appear or injury happen?	Date you advised the patient to cease/and or modify work activity

Planned course and duration of treatment *(include surgery and medications, if any)*

HOSPITALIZATION *(if applicable) Attach admission and discharge summaries*

Date admitted	Reason	Date discharged

Name of Hospital	Address	City	State	ZIP

PROGNOSIS

Since onset of symptoms, the patient's condition has: ☐ Improved ☐ Not changed ☐ Retrogressed

PHYSICAL IMPAIRMENT *(*As defined in Federal Dictionary of Occupational Titles)*

☐ Class 1 No limitation of functional capacity; capable of heavy work* no restrictions (0-10%)
☐ Class 2 Medium manual activity* (15-30%)
☐ Class 3 Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity* (60-70%)
☐ Class 5 Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)

In a work day given two breaks and a meal break, the patient must:

Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+
Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total hours	With positional change
Sit	8 7 6 5 4 3 2 1	*(hrs)*_____
Stand	8 7 6 5 4 3 2 1	*(hrs)*_____
Walk	8 7 6 5 4 3 2 1	*(hrs)*_____
Alternately Sit/Stand	8 7 6 5 4 3 2 1	*(hrs)*_____

Reach above shoulder	☐ Never	☐ Occasionally	☐ Frequently
Climb	☐ Never	☐ Occasionally	☐ Frequently
Crawl	☐ Never	☐ Occasionally	☐ Frequently
Bend/stoop	☐ Never	☐ Occasionally	☐ Frequently

Drive cars, trucks, forklifts and/or other equipment: ☐ Yes ☐ No
Be around moving equipment: ☐ Yes ☐ No
Walk on uneven ground: ☐ Yes ☐ No

CARDIAC *(if applicable) Functional Capacity (American Heart Association)*
☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
Blood Pressure (latest reading) _____ as of _____ Date Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

MENTAL/NERVOUS *(if applicable)*
Define "stress" as it applies to this patient

What effect has stress and, or problems in interpersonal relations had on the patient's ability to perform her/his job functions, if any?

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (No Limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (Slight Limitations)
☐ Class 3 – Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations (Moderate Limitations)
☐ Class 4 – Patient is not able to engage in stress situations or engage in interpersonal relations (Marked Limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Severe Limitations)

Axis I _____ Axis II _____ Axis III _____ Axis IV _____

Most recent GAF Score _____ Date of assessment _____ Highest GAF Score in the last year _____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

REHABILITATION/RETURN TO WORK When could trial employment begin?

PATIENT'S JOB:	**ANY OTHER WORK:**
☐ Full-time ☐ Part-time Date _____	☐ Full-time ☐ Part-time Date _____
☐ Unable to Determine: Follow-up in _____ weeks	☐ Unable to Determine: Follow-up in _____ weeks
☐ Never	☐ Never

Would job modification enable patient to work with impairment? ☐ Yes ☐ No If Yes, explain under Remarks.

Is the patient a suitable candidate for: (check as many as apply)

☐ Physical Therapy	☐ Cardiac Rehabilitation Program	☐ Work Hardening Program
☐ Occupational Therapy	☐ Cardiopulmonary Program	☐ Job Modification
☐ Speech Therapy	☐ Pain Management Program	☐ Other
☐ Vocational Rehabilitation	☐ Psychological Counseling	

Was this discussed with the patient? ☐ Yes ☐ No

Are you aware of any other disability income policies? ☐ Yes ☐ No If Yes, list Insurance Company Name and Policy Number

Insurance Company Name _____	Policy Number _____
Insurance Company Name _____	Policy Number _____

REMARKS

OTHER TREATING PHYSICIANS OR CONSULTANTS

Physician Name	Specialty	Phone Number

Name of Physician Completing This Form (Print)			Phone Number
Specialty	Tax ID Number		Fax Number
Address	City	State	Zip

I HEREBY CERTIFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature	Date

AIG

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.

Fraud Statement
PO Box L, Beattyville, KY 41311
Tel +1 866-960-0772, Fax +1 888-446-2390

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.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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.

ARKANSAS, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND, TEXAS, WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

DELAWARE, IDAHO, INDIANA, OKLAHOMA: WARNING—Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA, MAINE, TENNESSEE, VIRGINIA, WASHINGTON: WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may 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.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. 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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000). or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years

SIGNATURE OF INSURED _____ DATE _____