

Life Claims Claimant's Statement

Policy Numbers _____, _____, _____, _____

Information about the Deceased:

Claim Number _____

1. Name _____ Date of Death _____
First Middle Initial Last Mo. Day Year

2. Other Names by which the Deceased may have been known: _____

3. Last Address _____
Street Number Street Name Apt. Box # (if any)
City State Zip

4. Marital Status Married Single Widow/Widower Separated Divorced

5. Date of Birth _____ Place of Birth _____
Mo. Day Year

6. Is policy less than two years old? Yes No

7. Is a claim being made for Accidental Death Benefits? Yes No

If Policy Is Less Than Two Years Old please complete this section:

When did symptoms of last illness begin? _____

When was a doctor first consulted? _____

Doctor's Name: _____

Address _____ Phone # _____

Was there a hospital confinement? Yes No

Name and address of hospital: _____ Phone # _____

List names of doctors/hospital where treatment was received within the past five years:

Name: _____ Address: _____ Phone # _____

Dates of treatment: _____ Nature of Treatment: _____

Name: _____ Address: _____ Phone # _____

Dates of treatment: _____ Nature of Treatment: _____

If You Are Claiming Any Accidental Death Benefits please complete this section:
(Include copies of available newspaper clippings and/or police report giving circumstances)

Type of Accident: _____

Date: _____ Location: _____

Details: _____

Vehicle Accident:

Type of vehicle: _____ Name of driver _____

Homicide:

Motive? _____ Arrest made? Yes No

Suspects? (Give names) _____ Trial pending? Yes No

Witnesses? (Give names, addresses, phone numbers) _____

Suicide:

Investigation complete? Yes No Was a note left? Yes No (If yes, submit copy)

Witnesses? (Gives names, addresses and phone numbers) _____

AUTHORIZATION REGARDING _____ (“Insured)

I, the Claimant/Legal Representative of the Insured authorize any Insurance Company and American General Life Companies LLC (an affiliate services company) (collectively, the “Company”) and their authorized representatives including their employees and agents, to provide information to, and, to receive information from, MIB Inc., which operates an information exchange that assists insurance companies with benefit administration, claims, and fraud prevention and detection activities. This authorization will be valid for the duration of the claim or 24 months, which ever is longer. I understand that I may revoke it by giving written notice to the Company, but any action taken by the Company before receipt of such notice will be valid. I acknowledge that I am entitled to obtain a copy of the authorization and a copy will be as valid as the original.

Signature of Claimant/Legal Representative of the Insured

Printed Name

Date

The Claim Process

In order to expedite the processing of your claim, it is important that you submit a fully completed and signed Claimant’s Statement and a certified copy of the Insured’s death certificate. The particular circumstances of your claim may require the submission of additional information. Such as:

- **Claims by Estate** - If the executor or administrator of an estate is filing a claim, he or she must complete and sign the Claimant’s Statement and submit a copy of the appointment papers.
- **Beneficiary is a Minor** - If a legal guardian of the child’s estate has been appointed, he or she must sign the Claimant’s Statement and submit a copy of the guardianship papers.
- **Power of Attorney for the beneficiary** - You must attach a copy of the Power of Attorney authorization.
- **Assignment** - If benefits have been assigned to a funeral home or a financing company, we require an assignment form (provided by the assignee) be submitted. The assignment form must include the policy number(s), the dollar amount you wish to assign and the signature of the beneficiary.

If you need assistance completing this form, please contact us toll-free at 1-800-888-2452.

Please keep for your records

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American General Life and Accident Insurance Company, or its reinsurer(s), may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT CLAIM NOTICE

In some states we are required to advise you of the following: Any person who knowingly intends to defraud or facilitates a fraud against an insurer by submitting an application or filing a false claim, or makes an incomplete or deceptive statement of material fact, may be guilty of insurance fraud.

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 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 and 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 provided false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the 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, Oklahoma, Idaho, Indiana: 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.

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.

ALL OTHER RESIDENTS: A law of your state requires us to inform you that 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.



American General Life and Accident Insurance Company

HIPAA Authorization - Life Claims

Authorization to Obtain and Disclose Information

Name of Insured (Please Print) _____

Date of Birth _____

I, the Insured above or the personal representative of such Insured if deceased or under a legal disability, hereby authorize all of the people and organizations listed below to give American General Life and Accident Insurance Company, American General Life Companies LLC (an affiliated service company), and AGLA Service Company LLC (an affiliated service 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 the Insured's health (except psychotherapy notes) and the Insured'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; drug prescriptions, 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, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company which may have provided the Insured with life, accident, health, and/or disability insurance coverage, or to which the Insured may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- the Insured's employer, group policy holder, or benefit plan administrator;
- the Medical Information Bureau (MIB); and
- _____

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

- determine the Insured's 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 company listed above is subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG American General 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: American General Life and Accident Insurance Company, Attn: Life Claims Department - 380S, P.O. Box 305800, Nashville TN 37230-5800. I understand that my revocation of this authorization will not affect uses and disclosure of the Insured's health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under the Insured's 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 the Insured's 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, upon request, a copy of this authorization.

X _____
Signature of Insured or Insured's Personal Representative

Date

X _____
Printed Name

Relationship

X _____
Witness Signature (if required)

Date

Description of Authority of Personal Representative

Control Number/Policy Number