

**Accelerated Benefit Rider Claim Form**

**PART A - To be completed by Owner of the policy under which the claim is being filed.**

Policy Numbers \_\_\_\_\_

Other Policy Numbers under which a claim is being filed \_\_\_\_\_

Claimant/Owner's Contact Information

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

**For Policies with Accelerated Benefit Riders for Which Premiums Are Paid**

- I want to make a claim only for all Defined Accelerated Benefits provided for under the above Policy Numbers.
- I want to make a claim for all Defined Accelerated Benefits and for some or all Flexible Accelerated Benefits\* provided for under the above Policy Numbers.
- I want to make a claim under a Chronic Care Income Rider under one or more of the above Policy Numbers.

**For Policies with Accelerated Benefit Riders for Which No Premiums Are Paid**

- I want to make a claim for Flexible Accelerated Benefits\* provided for under the above Policy Numbers. (This option is not available for accelerated benefit riders for which premiums are paid.)

\* The actual payment received as a Flexible Accelerated Benefit, if any, will be less than the portion of the policy amount accelerated. If the claim is approved, the Company will send you documentation showing the amount you may elect to receive and will provide you an Election Form.

**-----Payment of Defined Accelerated Benefit Rider -----**

**If your insurance benefit is \$10,000 or more, you may elect to have the proceeds paid through a free, interest-bearing account called the Convenience Benefit Account<sup>®</sup>. (This option is not available for residents of Alaska, Arkansas, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York.)**

- This is a draft account whereby you may draw down the insurance proceeds and interest by drafting checks which are payable through State Street Bank and Trust Company.
- A personal checkbook will be mailed to you once your claim has been approved. You may access your account by writing a check for \$250.00 or more. If you wish, you can write a single check for the entire amount, including interest, to close your account. Your checks are payable through State Street Bank and Trust Company. The delivery of your checkbook constitutes payment of your full benefit amount.
- There are no monthly service charges, per-check charges or check fees. Fees will be charged for the following special services: any check presented for payment against insufficient funds, any stop payment order, and any check or statement copies. The charging bank reserves the right to change its fees at any time.
- Should your Convenience Benefit Account balance drop below \$1,500, the account will be automatically closed and a check for the balance mailed to you, with accrued interest on the 10<sup>th</sup> day of the following month.
- You will receive a monthly statement, showing all transactions, interest credited and the applicable rate(s) of interest for the period.
- Your Convenience Benefit Account earns interest at a periodic interest rate determined by the company which is set after monitoring current short term rates and other prevailing rates available in the marketplace.
- The interest rate is subject to periodic review and may be adjusted by the company. There is not a minimum interest rate credited to the account.
- Interest is compounded daily and credited to your account monthly. Interest may be taxable; please consult with your tax advisor regarding taxable interest amounts.
- To obtain the current interest rate for your account, please review your monthly statement or call 1-800-888-2402.
- Both your principal and any interest you earn are guaranteed by American General Life and Accident Insurance Company (AGLA).
- The Convenience Benefit Account is not insured by the Federal Deposit Insurance Corporation (FDIC). Its funds are guaranteed by the State Guaranty Associations. Please contact the National Organization of Life and Health Insurance Guaranty Associations ([www.nolhga.com](http://www.nolhga.com)) to learn more about coverage of your account.
- Account balances are the liability of AGLA, and AGLA reserves the right to reduce account balances for any payment made in error.
- Settlement options under any policy for which benefits are paid under a Convenience Benefit Account are preserved until the entire Convenience Benefit Account is withdrawn or the balance drops below \$1,500.00.
- If an initial life insurance benefit is less than \$10,000, AGLA will send you a check for the total benefit amount.
- Any value remaining in your Convenience Benefit Account may be transferred to the appropriate state authority as unclaimed property if no activity occurs in the account within the time period specified by applicable state law.

If you have questions regarding the Convenience Benefit Account, please call 1-800-888-2402 or write to AGLA, 366S American General Center, Nashville, TN 37250. For all other claim related questions, please call 1-800-888-2452.

**Select one of the following choices:**

- Please pay the insurance proceeds through the Convenience Benefit Account **(Not available if you are a resident of Alaska, Arkansas, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York).**
- Please pay the insurance proceeds by check.

**If you do not select one of the options above for payment, any proceeds payable will be paid by company check.**

Note: The signature on this Claimant's Statement will be used as your signature card for the Convenience Benefit Account.

Signature of Policyowner: \_\_\_\_\_ Date \_\_\_\_\_

**Statement of Irrevocable Beneficiary and Assignee (if any)**

Each undersigned hereby releases all rights, title, interest, and claim in and to any Accelerated Benefit Rider proceeds claimed as to the policy identified above. This release is in all respects absolute and no right, title, interest, or claim, vested or contingent, present or future, is reserved in the policy to the undersigned, or to anyone claiming through the undersigned (including but not limited to any Beneficiary designated under this policy), at this or any future time, for the benefits paid under the Accelerated Benefit Rider.

**Irrevocable Beneficiary or Assignee (Corporate or Individual)**

Name/Assignee \_\_\_\_\_ Signature \_\_\_\_\_

Title if Assignee \_\_\_\_\_ Date \_\_\_\_\_

**PART B – To be completed by the treating Physician who diagnosed the illness for which you are filing this claim.**

Date of Diagnosis \_\_\_\_\_ Diagnosis Code \_\_\_\_\_ Diagnosis Details \_\_\_\_\_

Anticipated Date of Life Expectancy (If terminally ill) \_\_\_\_\_

Check all Activities of Daily Living (ADLs) the Insured cannot perform.  Bathing  Contenance  Dressing  Eating  Toileting  Transferring

The insured has been unable to perform the checked ADLs beginning \_\_\_\_\_ through \_\_\_\_\_.

Doctor's Name, address and phone number (Name) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone number \_\_\_\_\_

Hospital Address (Name) \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone number \_\_\_\_\_

Doctor's License # \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART C – To be completed by the Insured**

Name of Insured Person \_\_\_\_\_

Insured Person's Date of Birth \_\_\_\_\_

When did symptoms of the condition for this claim begin? \_\_\_\_\_

When was a doctor first consulted for this condition? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_

Was there a hospital confinement for this condition? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_

**List names of all doctors/hospitals where treatment was received within the past five years for any illness or condition: If additional space is needed, submit additional names on a separate sheet of paper.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Nature of Treatment: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Name of Treatment: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Name of Treatment: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Name of Treatment: \_\_\_\_\_

AGREEMENT: the Insured Person agrees:

- (1) That all of the above statements and answers are complete and true to the best of his or her knowledge and belief; and
- (2) To cooperate with the Company in its investigation of this claim by providing assistance including, but not limited to, completing, signing, and submitting any questionnaire or authorization form needed by the Company, in its sole opinion, to conduct its investigation. I understand that no insurance agent of the Company is authorized to make any claim decision or any representation as to whether any claim should or will be paid. I acknowledge that, due to the requirements of certain medical providers and others as well as the requirements of applicable law, the authorization of someone other than myself may be required to acquire medical or other records necessary for the Company to consider my claim, potentially delaying the processing of such claim.

**INSURED PERSON SHOULD COMPLETE THE AUTHORIZATION TO RELEASE INFORMATION FORM AGLA2118C (ATTACHED)**

Signature of Insured Person \_\_\_\_\_ Date \_\_\_\_\_

(or in the case of a minor Insured Person by parent or legal guardian)

### **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 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 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.

## **Important Consumer Disclosures Regarding Accelerated Benefit Riders**

### **Disclosures Applicable to the Accelerated Benefit Rider**

- (1) When filing a claim for Qualifying Critical Illness or Qualifying Chronic Illness under an Accelerated Benefit Rider, the claimant must provide to the Company a completed claim form which must be received at its Home Office within the time frame specified in the Rider.
- (2) If a benefit under an Accelerated Benefit Rider is payable, the Company will provide the Owner with one (1) opportunity to elect a Flexible Accelerated Benefit under a Policy. The Owner must complete an election form and return it to AGLA within 60 days of receipt of the election form. The Company will not provide a later opportunity to elect a Flexible Accelerated Benefit under a Policy as to the same Qualifying Critical Illness or Qualifying Chronic Illness.

### **Disclosures Applicable to the Critical Illness Accelerated Benefit Rider, Chronic Illness Accelerated Benefit Rider, and Terminal Illness Accelerated Benefit Rider**

- (1) When filing a claim under a Critical Illness Accelerated Benefit Rider, the claimant must provide the Company a completed claim form within 365 days of the required Diagnosis by a Physician of an Insured Person's Critical Illness.
- (2) When filing a claim under a Chronic Illness Accelerated Benefit Rider, the claimant must provide the Company a completed claim form within 365 days of the required Certification by a Licensed Health Care Practitioner of an Insured Person's Chronic Illness.
- (3) If a benefit under an accelerated benefit rider is payable, the Company will provide the Owner with one (1) opportunity to elect an Accelerated Benefit under a Policy. The Owner must complete an election form and return it to AGLA within 60 days of receipt of the election form. The Company will not provide a later opportunity to elect an Accelerated Benefit under a Policy as to the same Critical Illness or Chronic Illness.

### **Disclosures Applicable to the Accelerated Benefit Rider and to the Critical Illness Accelerated Benefit Rider, Chronic Illness Accelerated Benefit Rider, and Terminal Illness Accelerated Benefit Rider**

- (1) The failure to provide a required claim form and a required election form within the periods set forth for each in a Policy may preclude payment of a benefit.
- (2) If you choose to receive an accelerated death benefit on account of a Chronic Illness or Terminal Illness, the sum included in Box 2 of the IRS Form 1099 LTC for "Accelerated death benefits paid" that you will receive will be the actual sum you received by check or otherwise, less any refund of premium or of loan interest that you received, plus any unpaid but due policy premium and, if applicable, a pro rata amount of any loan balance.
- (3) Benefits payable under an accelerated benefit rider may be taxable. If so, you may incur a tax obligation. Neither American General Life and Accident Insurance Company (AGLA) nor any agent representing it is authorized to give legal or tax advice. Please consult a qualified legal or tax advisor regarding questions concerning the information and concepts contained in this material.
- (4) See your policy for details.



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