American General Life and Accident Insurance Company
P. O. Box 1500
Nashville, TN 37202-1500

AGLA®
American General Life and Accident Insurance Company

Statement of Claim for Cancer, Hospital, Surgical and Accident Expense & Indemnity Policy Benefits

THE PATIENT IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.

TO BE COMPLETED BY INSURED

PART A - CLAIMANT/INSURED'S STATEMENT - TO BE COMPLETED FOR ALL CLAIMS

Name of Insured ______________________ Date of Birth ______________________

Address ______________________ Telephone No. (______) ______________________

Policy Number(s) ______________________

* *

Patient Name ______________________ Age ____________ Relationship ______________________

If over age 18, is dependent a full-time student? ____________ Where? ______________________

PART B - ACCIDENT CLAIMS: INSURED MUST COMPLETE THIS PORTION OF FORM

Date of Accident ______________________ Time ______________________

Complete Details of Accident ______________________

____

Location of Accident ______________________

TO BE COMPLETED BY HOSPITAL

PART C - HOSPITAL CLAIMS: TO BE COMPLETED BY HOSPITAL (or attach insurance copy of UB04)

1. Admitted On ______________________ Discharged On ______________________
2. Diagnosis From Records ______________________
3. Hospital ______________________
4. Address ______________________
5. Tax Identification Number (Required By Law) ______________________
6. National Provider Identifiers (NPI) (Required By Law) ______________________
7. Is any payment being made under Workers' Compensation or Medicare? ☐ Yes ☐ No
8. Signed By Title ______________________

TO BE COMPLETED BY INSURED

PART D - TO BE COMPLETED FOR ALL CLAIMS

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 agree 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 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.

____
Patient's Signature

Date ______________ Witness ______________________ Signature ______________________
If a minor child, parent's signature

NOTICE

IMPORTANT NOTICE (continued on next page)

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.

IMPORTANT NOTICE

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.

PART E - TO BE COMPLETED BY PHYSICIAN, SURGEON OR PROVIDER.

Patient & Insured (Subscriber) Information

1. Patient's Name (first name, middle initial, last name)
2. Patient's Date of Birth
3. Insured's Name (first name, middle initial, last name)
4. Patient's Address
5. Patient's Sex
   ☐ Male ☐ Female
6. Patient's Relationship to Insured
   ☐ Self ☐ Child
   ☐ Spouse ☐ Other
7. Insured's Policy Number
8. Other Health Insurance Coverage - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
9. Was Condition Related to Patient's Employment
   ☐ Yes ☐ No
10. Insured's Address (street, city, state, zip code)
11. Patient's or Authorized Person's Signature Signed ____________________ Date ____________

Physician or Supplier Information (must include medical provider address, telephone number, Tax ID No. and NPI No.)

12. Date of first systems of illness, date of accident. For Pregnancy (last monthly period).
13. Date First Consulted You for this Condition
14. Has patient ever had same or similar symptom?
    ☐ Yes ☐ No
15. Name of Referring Physician
16. For Services Related to Hospitalization Give Hospitalization Dates
    Admitted: Discharged:
17. Name & Address of Facility Where Services Rendered (if other than Home Office)
18. Was Laboratory Work Performed Outside Your Office?
    Yes ☐ No ☐
19. Diagnosis or Nature of Illness or Injury, Relate Diagnosis to Procedure in Columns D by Reference to Numbers 1, 2, 3, Etc. or DX Code ▼
    1.
    2.
    3.

20.

A. Date of Service	B* Place of Service	C. Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given — Procedure Code (identify:)	(Explain Unusual Services or Circumstances	D. Diag-nosis Code	E. Charges	F.

21. Signature of Physician or Supplier
    Signed Date
22. NPI (National Provider Identifier)
23. Total Charge
24. Amount Pd.
25. Balance Due
26. TIN (Tax I.D. No.)
27. Physician's or Supplier's Name, Address, City, State, Zip Code & Phone No.
28. Your Patient's Account No.
29. Your Employer I. D. No.

* Place of Service Codes

1 - (H)	- Inpatient Hospital	4 - (H)	- Patient's Home	7 - (NH)	- Nursing Home	O - (OL)	- Other Locations
2 - (OH)	- Outpatient Hospital	5 -	- Day Care Facility (Psy)	8 - (SNF)	- Skilled Nursing Facility	A - (IL)	- Independent Laboratory
3 - (O)	- Doctor's Office	6 -	- Night Care Facility (Psy)	9 -	- Ambulance	B -	- Other Medical / Surgical Facility

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

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HIPAA Authorization - Health Claims

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
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; and
- the Medical Information Bureau (MIB).

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: Health Claims Department, P.O. Box 1500, Nashville TN 37202-1500. 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 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 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

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