

STATEMENT FOR DISABILITY BENEFITS (Check appropriate box)

Disability Income Policy Disability Income Rider (DIR) Cancer Disability Waiver of Premium Rider (PW)

INSTRUCTIONS TO CLAIMANT: (Claimant's and physician's statements and HIPAA 2118C should be completed to expedite claim process).

Claimant's Name			Employer's Name		
Residence Address			Employer's Address		
City		State	City	State	Zip Code
Telephone Number ()		Zip Code	Employer's Telephone Number ()		
Date of Birth Date		Social Security Number	Current Monthly Earnings \$		
Date Last Worked		Describe your job/work/business duties and your title when disability began.			
		Is condition a result of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		Average monthly earnings for the two year period prior to disability \$			

IF ACCIDENT	IF SICKNESS
a. Describe what injury resulted	Describe nature and details of sickness
b. How did accident happen?	
c. Where did accident happen?	
d. Accident was: <input type="checkbox"/> work related <input type="checkbox"/> not work related	
e. Date of accident Date <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Date symptoms of illness first appeared Date
TREATMENT First treatment by a physician for this condition / /	Doctor's Name and Address
If hospitalized: Admitted / / Discharged / /	
Hospital Name	Hospital Address

Names and addresses of all physicians or practitioners and all hospitals or institutions by whom or in which you were attended, treated or examined during the last five years.

NAMES	ADDRESSES	DATES OF ATTENDANCE	DISEASE OR CONDITION

Have you ever had the same or similar injury or sickness? Yes No

If 'Yes', (a) What was the diagnosis at the time? _____

(b) When did this occur? _____

(c) Please give names and addresses of doctors and hospitals by whom or in which you were attended, treated or examined.

For purposes of this claim, I became Disabled _____ and such Disability continued/has continued to _____.

The first time I returned to work or place of business since becoming disabled was: Date _____ I returned to full time duties on: Date _____

For purposes of this claim, I became Partially Disabled _____ and such Disability continued/has continued to _____.

Of the occupational duties listed above, what duties were you not able to perform? Please describe why you were unable to perform these duties

COMPANY	TYPE	YEAR OF ISSUE	MONTHLY BENEFIT	POLICY NUMBER	BENEFIT PERIOD

<p>WORKER'S COMPENSATION</p> <p>(a) Have you received a monetary Worker's Compensation award? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) If yes, when did payment begin? ___/___/___</p> <p>(c) What amount did/are you receiving? \$ _____</p> <p>(d) The award was/is payable: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly</p> <p>(e) Give date if payments have ceased ___/___/___</p> <p>(f) Give name of worker's compensation carrier and claim number if known.</p> <p>(g) Provide the documentation to support the information given above.</p>	<p>STATE CASH SICKNESS (If you live in California, Hawaii, Puerto Rico, New Jersey, New York, Rhode Island)</p> <p>(a) Are you receiving benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) When did these benefits begin? ___/___/___</p> <p>(c) What amount are you receiving? \$ _____</p> <p>(d) Are you receiving these benefits <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly</p> <p>(e) Provide the documentation to support the information given above.</p>	<p>SOCIAL SECURITY BENEFITS</p> <p>(a) Have you applied for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) Have you been approved? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) Give total approved amount \$ _____</p> <p>(d) If denied, have you appealed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) Provide the documentation to support the information given above.</p>
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IMPORTANT – BE CERTAIN TO DATE AND SIGN THIS FORM AND HAVE YOUR TREATING PHYSICIAN COMPLETE THE ATTENDING PHYSICIAN'S STATEMENT PART C.

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.

Patient _____

Date _____ Witness _____ Signed _____

IMPORTANT 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.

8. PROGRESS

a. Has patient... Recovered Improved Unchanged Retrogressed

If recovered, date patient able to return to work? Date: _____

b. Has patient been hospital confined? Yes No Admitted _____ Discharged _____

Please give name and address of hospital

9. 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%)
 - Remarks:
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10. MENTAL/NERVOUS IMPAIRMENT (if applicable)

- Class 1 – Patient able to function under stress and able to engage in interpersonal relations (No limitations)
 - Class 2 – Patient able to function in most stress situations and engage in most interpersonal relations (Slight limitation)
 - Class 3 – Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation)
 - Class 4 – Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation)
 - Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation)
 - Remarks:
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11. REHABILITATION

- a. Is patient a suitable candidate for rehabilitation? Yes No
 - b. If yes, please explain
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12. REMARKS

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE
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NPI (National Provider Identifier)	*SOCIAL SECURITY OR TAX I.D. NUMBER			
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	TELEPHONE

* Public Law 89-397 requires recipients of dividend, interest or other payments to furnish Social Security Numbers or Tax Identification Numbers to payors required to report such payment to the Internal Revenue Service. This Number must be furnished to the payor whether or not the payee is required to file a tax return, or is covered by Social Security.



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