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

AGLA®
American General Life and Accident Insurance Company

Loss of Use, Dismemberment, And Loss of Vision

INSTRUCTIONS TO INSURED: Complete questions 1-11 and Section A, B, or C below for the type of claim you are filing. Have your physician complete the Attending Physician's Statement and the corresponding section for the type of claim you are filing. Return the completed form for review.

1. Name of Insured	2. Policy Number
3. Insured's Date of Birth	4. Present Occupation
5. Name and Address of Employer	6. Date Last Worked

7. Claimant/Owner's Name, Address, and Phone No.

Name ________________________________ Phone No. (_____) ______________________

Street ____

City ________________________________ State ______________ Zip Code ______________

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

NAME	ADDRESS	DATES OF ATTENDANCE	DISEASE OR CONDITION

9. If loss was due to an injury, when and how did injury occur? ________________________________

____

____

10. Who was present? ____

11. If loss was due to disease, date when disease had its onset or beginning: Month ______________ Day _______ Year ________

A. Complete this part if you are filing a LOSS OF VISION claim.

Is vision affected in: Right Eye____________________ Left Eye ______________________

When did you first notice any trouble with: Right Eye ______________________ Left Eye ______________________

When were you last able to see and recognize persons or objects with your: Right Eye ____________________ Left Eye __________________

B. Complete this part if you are filing an AMPUTATION claim.

Which limb or limbs have been severed or amputated? ____

Give the exact date of severance or amputation of each limb. ____

C. Complete this part if you are filing a LOSS OF USE (Paralysis) claim.

Which member or members have been paralyzed: ______________________________

State extent of loss of use of member or members: ______________________________

____

____

State improvement in your condition since onset: ______________________________

____

Please tell us how you wish to receive any benefits that may be payable to you.

______Lump Sum ______ Convenience Benefit Account (Requires a $10,000 minimum)

Date ______________________ Owner's Signature ______________________

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.

Owner's Certification of Social Security Number/Taxpayer Identification Number

Under penalties of perjury, I certify that:
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

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.

The Internal Revenue does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Social Security Number ______________________________

Signature of Owner ______________________________ Date ______________________

Attending Physicians Statement Loss of Use, Loss of Vision, or Dismemberment

The patient is responsible for the completion of this form without expense to the Company.

Complete this part for all types of claims- Signature required on last page

Patient's Name:	Patient's Date of Birth:
Diagnosis	When did symptoms first appear or accident happen?

Specify Type of Loss: Sight __________ Limb __________ Loss of Use ___________

Was the primary cause of the loss due to: ________ Disease _______ Injury

When did the patient first consult you on account of the disease or injury causing the loss?

List the names of any other physicians who have attended this patient, as reported to you. ______________________________

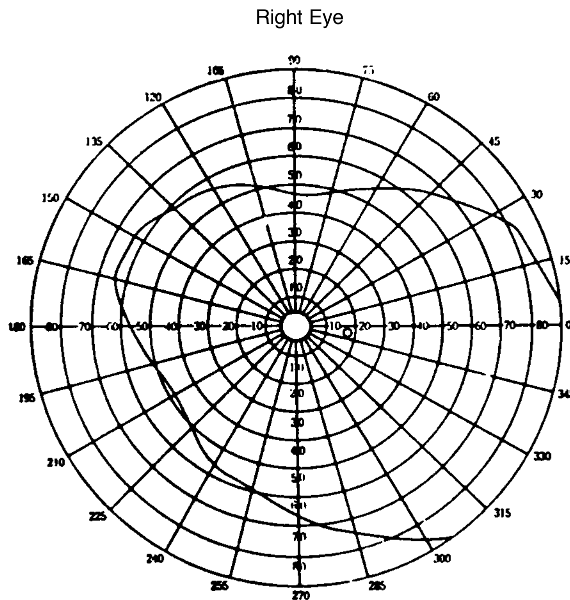
A. LOSS OF VISION-must be completed by Ophthalmologist

	(Snellen Notations)
1. What central vision, without lenses, existed in each eye at date of the first consultation?	Right Eye _____ Left Eye _____
2. What central vision, with lenses, existed in each eye at date of the first consultation?	Right Eye _____ Left Eye _____
3. At that time, how long did patient state that vision had been failing?	Right Eye _____ Left Eye _____
4. What central vision did patient have in each eye on date of last examination with correction by or aid of lenses?	Right Eye _____ Left Eye _____

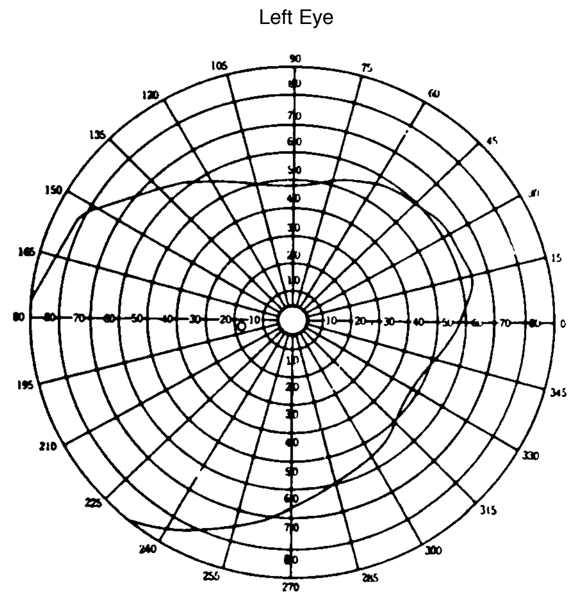
5. Is or are Fields of Vision contracted? Yes______ If yes, show extent on charts. No______

To be recorded where central vision is better than 20/200 and rough test shows a marked field defect.

Right Eye



Left Eye



6. What is the possibility of recovering vision, in whole or in part by:

O.D.	❑ Lenses	❑ Treatment	❑ Operation	❑ Not restorable
O.S.	❑ Lenses	❑ Treatment	❑ Operation	❑ Not restorable

7. In your opinion, has patient suffered a complete and irrecoverable loss of sight in ❑ OD ❑ OS ❑ Both

8. Have you recommended operation? Is so, when? ______________________________

   If not, why? ______________________________

9. What is the primary cause of loss of sight? ______________________________

10. What is the date of onset of the loss of sight? ______________________________

B. AMPUTATION (Indicate point of amputation below)

1. State which member is affected: ❑ Right Hand ❑ Left Hand ❑ Right Foot ❑ Left Foot ❑ Finger(s) ❑ Toe(s)

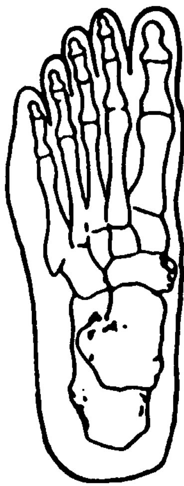
2. Point of Amputation: Right: ______________________________

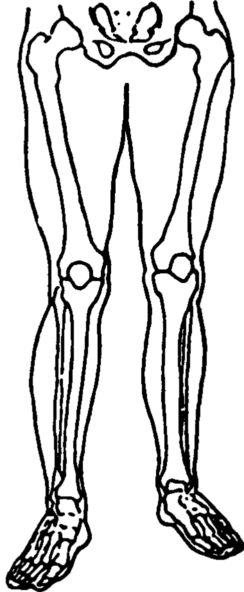
   Left: ______________________________

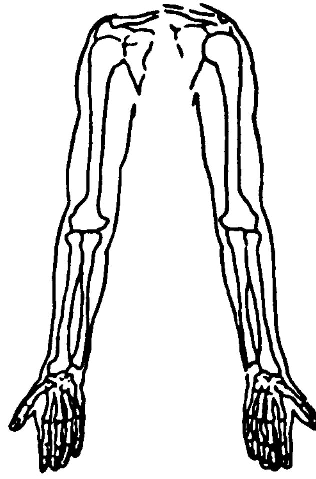
3. Date of Amputation: Right: ______________________________

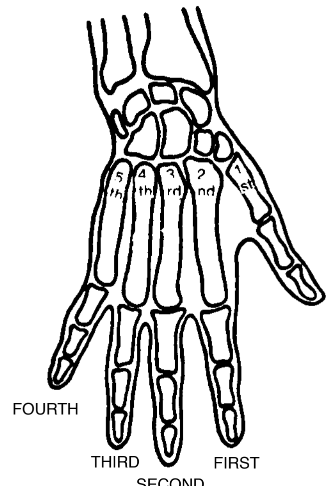
   Left: ______________________________

4. Please indicate the exact points of severance on the charts below:









C. LOSS OF USE (Paralysis)

1. What member or members are paralyzed? ______________________________

2. Describe fully the extent of paralysis of each member or members, and % of loss of use. ______________________________

3. Has there been a complete loss of use of a member or members? ______ Yes ______ No

4. In your opinion is paralysis permanent in each member involved? ______ Yes ______ No

5. If answer is Yes to #4, Since what date? Month ______________ Day ______ Year _________

Additional Comments: ______________________________

____

____

____

____

____

Physician's Name (Print) ______________________________ Date ______________

Physician's Signature ______________________________ Degree ______________

Street Address ______________________________

City ______________________________ State ________________ Zip Code ________________

Telephone No. (________)______________________________ Social Security or Tax Id No. ______________________________

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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

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