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

AGLA®
American General Life and Accident Insurance Company

Critical Illness Benefit Claim Form

PART A - To be completed by Insured

Insured/Patient must complete form 2118D to Obtain and Disclose information to expedite the claim process.

Name of Insured ____________________
Policy Number ____________________
Insured's Date of Birth ____________________
Claimant/Owner's Name, Address, and Phone No.
Name ____________________
Street ____________________
City____________ State ____ Zip Code ______
Phone No. (__) ______________

****SEE DEFINITION IN POLICY FOR THE CONDITION YOU SELECT****

____Invasive Cancer
____Kidney (Renal) Failure
____Coma
____Major Organ Transplant
____UNOS Advance Benefit* (see endorsement)
____Severe Burn
____Loss of Sight, Speech or Hearing
____Loss of Independent Living
____Health Screening (attach proof of type of screening)
____Medical Personnel HIV Benefit*
*(Rider must be present)

____Heart Attack
____Stroke
____Coronary Artery Bypass
____Paralysis
____Quadriplegia
____Paraplegia
____Hemiplegia
____In Situ Cancer
____Dismemberment Rider (Form 183 required)
____Return of Premium
____Benefit Extension Rider

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.

NAMES	ADDRESSES	DATES OF ATTENDANCE	DISEASE OR CONDITION

---------- Payment of Policy Proceeds ----------

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®. (This option is not available for residents of Alaska, Arkansas, Indiana, Kansas, Kentucky, 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 10th 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) 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, 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: ______________________________ Date: ________________

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.

Social Security Number/Taxpayer Identification Number ____________________

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.

Signature of Owner ____________________ Date ____________________

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

PART B - Attending Physician's Statement

When did symptoms first appear or accident happen? Date: ___________________________

Was condition due to: ______disease _______injury

Diagnosis Code: ____

Diagnosis Detail: ____

(if loss of sight list the ____

central vision in each eye ____

____

Has patient ever had a same or similar condition? ______Yes (explain) ______No

____

____

____

Duration of Coma based on your knowledge of patient's background. (If claiming Coma Benefit)

_____1-3 Months ______3-6 Months ______6-12 Months ______More than 12 months

Loss of Independent Living Benefit Claims-Select the activities of daily living that the insured is **permanently** unable to perform:

(See definition of each activity in the policy contract)

____Bathing ______ Transferring

____Dressing ______ Continence

____Toileting ______ Eating

Additional Remarks: ____

____

____

____

____

____

____

____

Doctor's Name____Date____________________

Street____

City ______________________________ State_______ Zip Code __________ Phone No.(____) ____________

Doctor's License # ______________ NPI #______________ Doctor's Signature ________________________

If hospitalized as a result of this condition:

Hospital Name ____ NPI # ____________________

Street____

City ______________________________ State_______ Zip Code __________ Phone No.(____) ____________

Admission Date: ______________________________Discharge Date ______________________________

© 2011 All rights reserved.

American General Life and Accident Insurance Company

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

AGLA2118D REV0110

© 2010 All rights reserved.