

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 that a claim is being filed on for this illness _____

Claimant/Owner's Name, Address, and Phone Number

Name _____

Street _____

City _____ State _____ Zip Code _____

Phone Number () _____

Select rider under which claim is filed

Accelerated Benefit Rider*

Chronic Care Income Rider

Important Notice: Coverage under an Accelerated Benefit Rider or under the ChronicCare Income Rider terminates on the date coverage under the policy or any covered riders terminates. We encourage you to read your policy and caution you to consider your options carefully before ever letting your policy lapse for any reason, including the non-payment of premium, especially while an ABR claim is pending.

* The actual payment received, 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.

Your Signature: 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.

X _____
Owner's Signature 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 Continence 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

California Residents: CAUTION: 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 Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or 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 provides 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.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties 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. **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.**

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 \$5,000 and the state value of the claim for each such violation.

Oregon Residents: Any person who, knowingly and with intent to defraud any insurance company or other person; (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: 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.

Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

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.



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 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 my health (except psychotherapy notes) and my 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 me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my 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 my 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 my 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 my 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