American General Life and Accident Insurance Company
P O Box 305800
Nashville TN 37230-5800

AGLA
American General Life and Accident Insurance Company

Life Claims Claimant's Statement

Policy Numbers _____ , _____ , _____ , _____

Information about the Deceased: **Claim Number** _____

1. Name _____ Date of Death _____
   First Middle Initial Last Mo. Day Year
2. Other Names by which the Deceased may have been known: _____
3. Last Address _____
   Street Number Street Name Apt. Box # (if any)

   _____
   City State Zip
4. Marital Status ❑ Married ❑ Single ❑ Widow/Widower ❑ Separated ❑ Divorced
5. Date of Birth _____ Place of Birth _____
   Mo. Day Year
6. Is policy less than two years old? ❑ Yes ❑ No
7. Is a claim being made for Accidental Death Benefits? ❑ Yes ❑ No

If Policy Is Less Than Two Years Old please complete this section:

When did symptoms of last illness begin? _____

When was a doctor first consulted? _____

Doctor's Name: _____

Address _____ Phone # _____

Was there a hospital confinement? ❑ Yes ❑ No

Name and address of hospital: _____ Phone # _____

List names of doctors/hospital where treatment was received within the past five years:

Name: _____ Address: _____ Phone # _____

Dates of treatment: _____ Nature of Treatment: _____

Name: _____ Address: _____ Phone # _____

Dates of treatment: _____ Nature of Treatment: _____

If You Are Claiming Any Accidental Death Benefits please complete this section:

(Include copies of available newspaper clippings and/or police report giving circumstances)

Type of Accident: _____

Date: _____ Location: _____

Details: _____

Vehicle Accident:

Type of vehicle: _____ Name of driver _____

Homicide:

Motive? _____ Arrest made? ❑ Yes ❑ No

Suspects? (Give names) _____ Trial pending? ❑ Yes ❑ No

Witnesses? (Give names, addresses, phone numbers) _____

_____

Suicide:

Investigation complete? ❑ Yes ❑ No Was a note left? ❑ Yes ❑ No (If yes, submit copy)

Witnesses? (Gives names, addresses and phone numbers) _____

Information about You:

1. Your Name (please print or type)_____ Your date of birth _____
   First Middle Initial Last
2. Your Phone Number (in case we need to contact you): Day _____ Evening _____
3. Your Mailing Address _____
   Street Number Street Name Apt. Box (if any)

   _____
   City State Zip
4. Your relationship to the Insured. You are the: ❑ Spouse ❑ Child ❑ Other _____
   Please Explain
5. Have you given a funeral home an assignment to collect any amount due under this claim? ❑ Yes ❑ No

   Name of funeral home_____

   Phone # _____ Amount assigned: $ _____

------- 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 in your name.

- This account, called the Convenience Benefit Account® is a safe, secure place to keep your proceeds while you decide how to best use them.
- A personal checkbook will be mailed to you once your claim has been approved. You may access all or part of the money simply by writing a check for $250.00 or more. Any amount that remains in the account will continue to earn interest.
- Both your principal and any interest you earn are guaranteed by American General Life and Accident Insurance Company (AGLA). The establishment of a Convenience Benefit Account satisfies AGLA's contractual obligation for the payment of certain insurance proceeds. The Convenience Benefit Account is not insured by the Federal Deposit Insurance Corporation or any federal agency.
- Account balances are the liability of AGLA, and AGLA reserves the right to reduce account balances for any payment made in error.
- If an initial life insurance benefit is less than $10,000, AGLA will send you a check for the total benefit amount.

❑ Please pay the insurance proceeds through the Convenience Benefit Account.

If you do not choose to take advantage of the Convenience Benefit Account, select one of the following choices:

❑ Please pay the insurance proceeds by check.

❑ Please pay the insurance proceeds by means of a Settlement option permitted by the Policy (please refer to settlement options in the policy and indicate your preference):

If you do not select one of the options above for payment, the proceeds will be paid into the Convenience Benefit Account if the amount is $10,000 or more. Otherwise, the proceeds will be paid by check.

Note: The signature on this Claimant's Statement will be used as your signature card for the Convenience Benefit Account.

Your Social Security Number/Tax 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 the 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 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 an U.S. person (including an 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. The IRS does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

❑ I elect NOT to have Federal Income Tax withheld from the TAXABLE PORTION of my distribution.

❑ I elect to have Federal Income Tax withheld from the TAXABLE PORTION of my distribution.

Your Signature: 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.

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.

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

X _____ _____
Beneficiary's Signature – PLEASE SIGN AS YOU WOULD SIGN A CHECK Date

Please keep for your records

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American General Life and Accident Insurance Company, or its reinsurer(s), may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AGLA MIB (1004)

The Claim Process

In order to expedite the processing of your claim, it is important that you submit a fully completed and signed Claimant's Statement and a certified copy of the Insured's death certificate. The particular circumstances of your claim may require the submission of additional information. Such as:

- **Claims by Estate** - If the executor or administrator of an estate is filing a claim, he or she must complete and sign the Claimant's Statement and submit a copy of the appointment papers.
- **Beneficiary is a Minor** - If a legal guardian of the child's estate has been appointed, he or she must sign the Claimant's Statement and submit a copy of the guardianship papers.
- **Power of Attorney for the beneficiary** - You must attach a copy of the Power of Attorney authorization.
- **Assignment** - If benefits have been assigned to a funeral home or a financing company, we require an assignment form (provided by the assignee) be submitted. The assignment form must include the policy number(s), the dollar amount you wish to assign and the signature of the beneficiary.

If you need assistance completing this form, please contact us toll-free at 1-800-888-2452.

AUTHORIZATION REGARDING _____ **("Insured)**

I, the Claimant/Legal Representative of the Insured authorize any Insurance Company and American General Life Companies LLC (an affiliate services company) (collectively, the "Company") and their authorized representatives including their employees and agents, to provide information to, and, to receive information from, MIB Inc., which operates an information exchange that assists insurance companies with benefit administration, claims, and fraud prevention and detection activities. This authorization will be valid for the duration of the claim or 24 months, which ever is longer. I understand that I may revoke it by giving written notice to the Company, but any action taken by the Company before receipt of such notice will be valid. I acknowledge that I am entitled to obtain a copy of the authorization and a copy will be as valid as the original.

_____ _____

Signature of Claimant/Legal Representative of the Insured | Printed Name

_____

Date

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.

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.

AGLA

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