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 10 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 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.
❑ 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, 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:____________________

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

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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

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.

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)

IMPORTANT CLAIM 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.

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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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