AIG

AIG
Group Benefits

American General Life Insurance Company*
Houston, Texas
The United States Life Insurance Company in the City of New York
New York, New York
National Union Fire Insurance Company of Pittsburgh, Pa
New York, New York
*This company does not solicit business in New York

Proof of Group Death Claim
PO Box 14294, Lexington, KY 40512
Tel +1 800-289-2266
Fax +1-855-864-0530
Email: claimsubmission@groupclaims.com

PLEASE ANSWER ALL QUESTIONS FULLY AS THIS WILL HELP EXPEDITE THE EVALUATION OF THIS CLAIM.

POLICYHOLDER'S STATEMENT

Name of Insured	Date of Birth	Date of Death	Social Security Number

Address	City	State	Zip Code

Name of Employer	Telephone Number	Group Policy Number	Certificate Number

Address	City	State	Zip Code

☐ Union Employee ☐ Full Time ☐ Part Time ☐ Non-Union Employee ☐ Full Time ☐ Part Time	Average Number of Hours Worked Per Week

Last Full Day of Active Work	Reason for Stopping Work ☐ Illness ☐ Leave of Absence ☐ Retirement ☐ Lay Off ☐ Other *(Explain briefly)*

If Due To Illness, Disability Benefits were Paid From: _____ To: _____	Ins. Company's Name

Ins. Company's Address	City	State	Zip Code

Date Employed	Employee's Job Title	Amount of Insurance	Weekly Earnings	Insurance Class

If Contributory Insurance, to What Date Has Employee's Contribution Been Paid From:_____ To:_____

Beneficiary Name (If Estate, Certified Copy of Court Order Appointing Executor or Administrator Should be Attached)

Address	City	State	Zip Code	Relationship	Age

Guardian Name (If Beneficiary is a Minor, a Certified Copy of Court Order Appointing Guardian Should be Attached)

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Policyholder's Official Representative

PHYSICIAN'S STATEMENT: ***To be completed if Decedent was disabled more than 31 days prior to death.***

Name of Insured	Date of Death	Age

Date of First Visit	Date of Last Visit	Place of Death

Immediate Cause of Death	Duration	Contributory Causes or Complications	Duration

Death Resulted From: ☐ Natural Causes ☐ Accident ☐ Suicide ☐ Homicide
If Due to Accident, Suicide, or Homicide, Describe Briefly:

Insured was Totally Disabled and Unable to Perform Work From: _____ To _____

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Physician Completing This Form (Print)	Signature	Date

Address	City	State	Zip Code

Telephone Number	Fax Number

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CLAIMANT'S STATEMENT: COMPLETE SIGN AND DATE THIS FORM, THE AUTHORIZATION FOR RELEASE OF INFORMATION AND THE FRAUD STATEMENT. A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST BE ATTACHED. THE DEATH CERTIFICATE WILL NOT BE RETURNED.

Name of Insured	Date of Birth	Date of Death	Social Security Number

Address	City	State	Zip Code

Cause of Death	Place of Death

Date Insured First Gave Indication of His/Her Last Illness	Date Insured First Consulted a Physician for His/Her Last Illness

Was Death the Result of an Accident? ☐ Yes ☐ No	Date of Accident	Place of Accident	Did Accident Occur in Course of Employment? ☐ Yes ☐ No

Briefly Describe Accident

List name and address of physicians, hospitals and institutions, if any, the Insured visited during his/her last illness and during the five years prior to that illness. Also list date(s) of visit(s) and condition(s) treated.

Name	Address	Date(s) of Visit(s)	Condition(s)

Provide the following information concerning any other insurance the Insured had.

Name of Insurance Company	Address	Policy Dated	Amount of Insurance

In what capacity do you claim this insurance? ☐ Beneficiary ☐ Other _____
(If administrator, executor or guardian, attach copy of court order of appointment.)

PLEASE READ THE SECTION ENTITLED IMPORTANT INFORMATION REGARDING CLAIM PAYMENT

I elect to receive payment by:

☐ **Lump Sum–Instant Access Account**
If proceeds are paid by the Instant Access Account, a check may be written for the full amount as soon as the checkbook is received. Not available for amounts less than $50,000. Not available in all states.

☐ **Lump Sum check**

If this is a trust or estate - do not furnish the taxpayer ID# of the personal representative or trustee unless the legal entity itself is not designated in the account title/beneficiary name. The beneficiary name must match with the beneficiary taxpayer ID #.

Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or correct Taxpayer ID number; and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) in this paragraph if you are subject to backup withholding and cross out item (3) in this paragraph if you are not a U.S. person (including a U.S. resident alien).

If this beneficiary is a non U.S. person an IRS form W-8 must be completed, reviewed and approved prior to any payment of funds.

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Beneficiary's Name (Print)		Beneficiary's Date of Birth		Relationship to Deceased

Address	City	State	Zip Code	Telephone Number

Beneficiary's Tax Payer ID# (SSN, ETIN, whichever is applicable)	Signature of Beneficiary, with Title, if any (U.S. person, including a U.S. resident alien)	Date

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Authorization for Release of Medical Information

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Fax +1-855-864-0530
Email: claimsubmission@groupclaims.com

DECEASED'S NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company, The United States Life Insurance Company in the City of New York and National Union Fire Insurance Company of Pittsburgh, PA, (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 Deceased's health (except psychotherapy notes) and the Deceased'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; 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 or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG Company which may have provided the Deceased with life, accident, health, and/or disability insurance coverage, or to which the Deceased may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- the Deceased'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 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 companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG Company 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: AIG-Group Benefits, PO Box 14294, Lexington, KY 40512. I understand that my revocation of this authorization will not affect uses and disclosure of the Deceased'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 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 a copy of this authorization.

NAME OF CLAIMANT (PRINT)

SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE

DATE

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FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:
Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

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.

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 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 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: 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: 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.

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

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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.

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.

SIGNATURE OF INSURED _____ DATE _____

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Important Information Regarding Claim Payment

Making financial decisions at an emotional time can be difficult. One method of payment that may be available to help you is through the Instant Access Account ("Account"). The Instant Access Account is designed to provide you with immediate access to the funds, while allowing you all the time you need to consider how you wish to use your insurance benefit. Other available settlement options are preserved until the entire balance is withdrawn or the balance drops below the minimum payment requirement.

If total payments are $50,000 or more you may choose to receive payment through the Instant Access Account option. The Account is an interest earning account in your name. The proceeds are payable to you as the beneficiary of a life insurance policy. This is a draft account whereby you may draw down insurance proceeds and interest by drafting checks which are payable through State Street Bank and Trust Company. This is a convenient, easy option that gives you great flexibility. By writing a check using the provided checkbook, you may access funds immediately, or, in the future after you have had the opportunity to consider all of your financial options.

Some of the Instant Access Account features include:

Immediate Access: The Instant Access Account gives you immediate access to your money starting on the day you receive your checkbook. You may withdraw all or part of your money at any time. You cannot make deposits into the Account.

Time to Decide: The Instant Access Account allows you to defer making long term investment decisions and provides time to consider your options.

Convenient: To access funds, simply write a check for at least $250 to yourself or to any third party. There are no monthly service charges, per-check charges or check fees. Fees will be charged for special services.

Interest Rates: The Instant Access Account earns 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. Interest is compounded daily and credited to your account monthly. There is not a minimum interest rate credited to the account. Interest may be taxable; please consult with your tax advisor regarding taxable interest amounts. To obtain the current interest rate the program is offering please call 1-800-331-4631.

Toll Free Service: Questions regarding your account will be answered via a toll free telephone number provided to you with your Instant Access Account checkbook.

Record Keeping: Proceeds paid through the Instant Access Account allow for easy record management through the receipt of monthly statements. The monthly statements will provide your current balance, account activity, interest earned and interest rate paid. Account holders with no activity will receive a quarterly statement. No activity for an extended period of time, as specified by your individual state law, could result in funds being transferred to the appropriate state under their unclaimed property laws.

If you choose the Instant Access Account a Welcome Kit will be sent to you that includes:

- A book of personalized checks that give the beneficiary the ability to write a check as soon as they are received.
- A Certificate of Account Confirmation and Terms and Conditions.
- A pamphlet detailing your account options and features.

Please note that benefits will not be payable by way of the Instant Access Account if any of the following circumstances exist:

- The benefits payable are less than $50,000. If the amount payable is less than $50,000, a lump sum check will be issued to you.
- The beneficiary is a minor, corporation, partnership, estate, trust or guardianship.
- The beneficiary resides in Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, New York, Rhode Island or outside the U.S.
- The type of policy or contract does not offer the payment option of an Instant Access Account

Additional Options

You may request a lump sum settlement check or your insurance policy or contract also may provide other settlement options for payment. Please refer to the insurance contract regarding these settlement options.

Open Solutions BIS Inc. is the administrator of the Instant Access Account. Check clearing is provided by State Street Bank and Trust Company, Boston, MA. **Retained asset accounts funds are not guaranteed by the Federal Deposit Insurance Corporation (FDIC)**. The funds are guaranteed by the state guaranty associations. Please contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com). Open Solutions BIS Inc. and State Street bank and Trust Company are not affiliates of United States Life Insurance Company, American General Life Insurance Company, or National Union Fire Insurance Company of Pittsburgh, Pa.