

American General Life Insurance Company of Delaware

Wilmington, Delaware

American International Life Assurance Company of New York

New York, New York

The United States Life Insurance Company in the City of New York

New York, New York

MAIL TO: P.O. Box 30083, Tampa, FL 33630-3083, 877-672-1648

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	
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Address	City	State	Zip Code
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Name of Employer	Telephone Number	Group Policy Number	Certificate Number
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Address	City	State	Zip Code
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<input type="checkbox"/> Union Employee	<input type="checkbox"/> Full Time	<input type="checkbox"/> Non-Union Employee	<input type="checkbox"/> Full Time	Average Number of Hours Worked Per Week
	<input type="checkbox"/> Part Time		<input type="checkbox"/> Part Time	

Last Full Day of Active Work	Reason for Stopping Work	<input type="checkbox"/> Illness	<input type="checkbox"/> Leave of Absence	<input type="checkbox"/> Retirement	<input type="checkbox"/> Lay Off
	<input type="checkbox"/> Other (Explain briefly)				

If Due To Illness, Disability Benefits were Paid From: _____ To: _____	Carrier's Name
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Carrier's Address	City	State	Zip Code
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Duration of Employment	Employee's Job Title	Weekly Earnings	Insurance Class
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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
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Guardian Name (If Beneficiary is a Minor, a Certified Copy of Court Order Appointing Guardian Should be Attached)

Send Check To

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

Signature of Policyholder's Official Representative	Date
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PHYSICIAN'S STATEMENT: To be completed if Decedent was disabled more than 31 days prior to death.

Name of Insured	Date of Death	Age
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Date of First Visit	Date of Last Visit	Place of Death
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Immediate Cause of Death	Duration	Contributory Causes or Complications	Duration
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Death Resulted From: <input type="checkbox"/> Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
If Due to Accident, Suicide, or Homicide, Describe Briefly:

Insured was Totally Disabled and Unable to Perform Work From: _____ To _____
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THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Physician Completing This Form (Print)	Signature	Date
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Address	City	State	Zip Code
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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.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident	Place of Accident		Did Accident Occur in Course of Employment? <input type="checkbox"/> Yes <input type="checkbox"/> 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.)

Original Certificate of Insurance must be returned if available. Certificate enclosed Certificate cannot be located

I elect to receive payment by: immediate availability of funds from an interest-bearing checking account* with free check writing privileges.
 lump sum payment by check
 as a non-cash settlement option (Please specify and if necessary, contact your insurance plan administrator for a description of non-cash settlement options available) _____

*If your proceeds are eligible and exceed the current applicable minimum (\$5,000) set by the Company, an interest-bearing checking account will be established in your name. You may immediately write a check for the full amount or leave your account open and draw money only as you need it. Meanwhile, the funds will earn interest at the variable rate currently effective for The United States Life Insurance Company in the City of New York, American General Assurance Company Instant Access Accounts payable through State Street Bank and Trust Company. The Instant Access Account is not available to estates, trusts or guardianships.

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
Witness Signature					Date

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DECEASED'S NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
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I hereby authorize all of the people and organizations listed below to give AG Life Insurance Co. of DE, American International Life Assurance Company of New York, The United States Life Insurance Company in the City of New York and the American General Life Companies 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 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 American General 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 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: AG Tampa Solutions Center, P.O. Box 30083, Tampa, FL 33630-3083. 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 CLAIMANT/GUARDIAN/REPRESENTATIVE

DATE