AIG AMERICAN GENERAL

Request to Continue Supplemental Medical Products

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

New York, New York

Administrative Office: P.O. Box 30066, Tampa, FL 33630-3066
Phone: 1-877-672-1648 Fax: 1-877-672-1650

PLEASE PRINT OR TYPE ALL INFORMATION REQUESTED. COMPLETE IN FULL AND PROVIDE ALL NECESSARY SIGNATURES. SEE NEXT PAGE FOR COMPLETE INSTRUCTIONS.

1. Group Policy No. ____________________ 2. Issued To ____________________
   NAME OF EMPLOYER

3. Employee's Full Name ______________________________
   FIRST *MIDDLE* *LAST*

   Employee's Date of Birth ____________________ ____________________
   MO. *DAY* *YR.* *SOCIAL SECURITY NUMBER*

   Name of Beneficiary ______________________________ Relationship ____________

4. Spouse's Full Name ______________________________
   FIRST *MIDDLE* *LAST*

   Employee's Date of Birth ____________________ ____________________
   MO. *DAY* *YR.* *SOCIAL SECURITY NUMBER*

   Name of Beneficiary ______________________________ Relationship ____________

5. Eligible Dependent Children To Be Continued? ☐ Yes ☐ No If yes, provide date of birth for the youngest covered dependent child ____________________

6. Employee's Billing Address ______________________________
   NUMBER *STREET* *CITY* *STATE* *ZIP CODE*

7. Date Employee's Employment Terminated ____________________
   MO. *DAY* *YR.*

8. Reason For Termination Of Employment ______________________________

9. Please check the group worksite product(s) you wish to continue: ☐ Accident ☐ Hospital Indemnity
   ☐ Critical Illness: Amount $____________ ☐ Cancer: Amount $____________

10. Select One Billing Mode: ☐ Annual ☐ Semiannual ☐ Quarterly

    The applicable billing fees are:
    Annual = $20 per bill ($20 per year)
    Semiannual = $15 per bill ($30 per year)
    Quarterly = $10 per bill ($40 per year)

11. Employee Premium $ ____________ Employee & Spouse or Emp. +1 Premium $____________
    Employee & Child(ren) Premium $____________ Family Premium: $ ____________
    Amount of Premium Check sent with this request $ ____________

YOUR CHECK TOTALLING THE FIRST FULL PREMIUM FOR EACH INSURED PLUS THE APPROPRIATE BILLING FEE MUST ACCOMPANY THIS REQUEST.

IMPORTANT NOTE: IF THE MASTER GROUP POLICY ENDS, YOUR COVERAGE UNDER THIS CONTINUATION OPTION WILL END.

Signature of Employee ______________________________ Date Signed ____________

Signature of Spouse ______________________________ Date Signed ____________

THIS SECTION MUST BE COMPLETED BY YOUR EMPLOYER

I verify the following:

Current amount of coverage for Employee $____________ Monthly premium $ ____________

Current amount of coverage for Employee & Spouse/Employee +1 $____________ Monthly premium $ ____________

Current amount of coverage for Employee & Child(ren) $____________ Monthly premium $ ____________

Current amount of coverage for Family $____________ Monthly premium $ ____________

Premium is paid through: ____________________
MO. *DAY* *YR.*

______________________________ ____________
SIGNATURE OF EMPLOYER REPRESENTATIVE *DATE SIGNED*

INSTRUCTIONS FOR COMPLETING THE REQUEST TO CONTINUE SUPPLEMENTAL MEDICAL PRODUCTS

1. You are eligible to continue your coverage after termination of employment if so stated in your certificate of insurance. Your lawful spouse and eligible dependent children, if insured, are also eligible to continue their coverage, but only if you continue your coverage. You must apply within 30 days of your termination date.
2. Be sure to fill this form out completely and obtain the appropriate signatures. You must obtain a signature from a representative of your employer.
3. Submit a check for the appropriate premium plus the billing fee. If you do not know your premium amount, call your employer and ask for the monthly premium figures. Multiply the total premium by the appropriate months for the mode you are selecting (x12 for annual, x6 for semiannual, x3 for quarterly) and add the billing fee. Your request will not be processed without the appropriate check.
4. You will receive a billing statement as soon as your request is processed.
5. Make your check payable to: **The United States Life Insurance Company in the City of New York**
6. Mail this request to: **American General Life Co.**
P.O. Box 30066
Tampa, FL 33630-3066