AIG AMERICAN GENERAL

INSTRUCTIONS FOR FILING INITIAL PROOFS FOR WAIVER OF PREMIUM BENEFITS

1. Before submitting initial claim proofs for Waiver of Premium Benefits, the claimant must have been totally disabled and unable to engage in any type of occupation for wage or profit for at least nine consecutive months.

2. After the condition noted above has been met, the following forms must be completed in their entirety and returned to us:

   a) The **Claimant's Statement** completed by the employee or association member;

   b) The **Employer's Statement** completed by the Employer, Union or Association whichever may be applicable;

   c) The **Attending Physician's Statement** completed by the claimant's physician(s) who can certify disability from the date last worked.

3. We require the claimant's original enrollment card and beneficiary changes, if any.

4. If your group life insurance schedule of benefits is based on salary, we require copies of the claimant's payroll records for the three month period immediately preceding the date the disability commenced.

5. Any other information that you feel is pertinent together with the above should be forwarded to:

   The United States Life Insurance Company
   Attention: Policy Benefits Life / 2-K
   3600 Route 66
   P O Box 1580
   Neptune NJ 07754-1580

   800-250-8898

AIG AMERICAN GENERAL

Employer's Statement
Waiver of Premium Benefit

AIG Life Insurance Company
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
Member companies of American International Group, Inc.
Administrative Office: 3600 Route 66, P.O. Box 1580, MSN 2K, Neptune, NJ 07754-1580

TO BE COMPLETED BY THE EMPLOYER OR DULY AUTHORIZED AGENT

Name of Insured			Telephone Number	
Address	City		State	Zip Code
Group Policy Number	Certificate Number	Insurance Classification		
Name of Employer			Telephone Number	
Address	City		State	Zip Code
Nature of Business				
Insured's job title			Average number of hours worked per week	
Describe the job requirements performed by the Insured prior to disability				
Date of hire	Date Insured was unable to perform partial duties	Date Insured was unable to perform all duties	Last full day worked	
Is Insured's illness or injury the sole cause of absence? ☐ Yes ☐ No If No, explain				
Has Insured been absent from work before because of any illness or injury? ☐ Yes ☐ No If Yes, describe				
Date premium payments terminated on Insured's coverage	If not yet terminated, give expected date of termination			
Amount of Insurance (This should be the amount of coverage as of the last day worked.)				
Name of Person Completing this Form (Print)		Title		

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

Signature	Date

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY

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Claimant's Statement
Waiver of Premium Benefit

THIS STATEMENT MUST BE FULLY ANSWERED BY THE INSURED OR DULY APPOINTED GUARDIAN OR CONSERVATOR. IF INSURED IS UNABLE TO ANSWER THESE QUESTIONS A BENEFICIARY OR NEAREST RELATIVE MAY DO SO.

COMPLETE, SIGN AND DATE THIS FORM, THE AUTHORIZATION FOR RELEASE OF INFORMATION AND THE FRAUD STATEMENT AND SEND ALL DOCUMENTS TO YOUR EMPLOYER.

Name of Insured			Date of Birth
Address	City	State	Zip Code
Telephone Number	Social Security Number	Height	Weight
Name of Employer	Group Number	Telephone Number	
Address	City	State	Zip Code
Occupation/Job Title at time of disability	Last day worked	Date of illness/injury	First day absent from work for this disability

Medical condition preventing you from working

Describe what limitations are preventing you from working

Have you worked in any capacity since your disability began? ☐ Yes ☐ No If Yes, briefly describe

Attending Physician's Name			Telephone Number
Address	City	State	Zip Code
First office visit	Last office visit	Next office visit	
List additional provider's name			Telephone Number
First office visit	Last office visit	Next office visit	
Were you hospitalized? ☐ Yes ☐ No	If Yes, hospital name	Date admitted	Date discharged
Hospital Address	City	State	Zip Code

Provide the following information concerning any other insurance you have:

Name of Insurance Company	Address	Amount of Insurance

Are you represented by a Guardian or Conservator? ☐ Yes ☐ No If Yes, provide a Copy of Appointment

Name of Person Completing This Form (Print)	Telephone Number
Signature of Insured, Guardian or Conservator	Date

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY

AIG AMERICAN GENERAL

Authorization for Release of Information

AIG Life Insurance Company
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
Member companies of American International Group, Inc.
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CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, 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 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; 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 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; and
- the Medical Information Bureau (MIB).

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 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 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: AIG American General, P.O. Box 1580, Neptune, NJ 07754-1580. 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 a copy of this authorization.

NAME OF CLAIMANT (PRINT)

SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE

DATE

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Fraud Statement

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 _____

AIG AMERICAN GENERAL

Attending Physician's Statement
Waiver of Premium Benefit

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THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.

Name of Patient			Date of Birth
Address	City	State	Zip Code
Employer Name		Policy Number	

HISTORY

When did symptoms first appear or accident happen? ..... Month _____ Day _____ Year _____

Date patient was unable to work because of disability ..... Month _____ Day _____ Year _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe _____

Is condition due to injury or sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown

Names and addresses of other treating physicians

DIAGNOSIS

Diagnosis (including any complications) _____

Subjective symptoms _____

Objective findings (include current X-rays, EKGs, Laboratory Data and any clinical findings) _____

DATES OF TREATMENT

Date of first visit _____ Date of last visit _____ Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify) _____

NATURE OF TREATMENT *(including surgery and medications prescribed, if any)*

PROGRESS

Patient has ..... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Patient is ..... ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

HOSPITALIZATION

Has patient has been hospital confined? ☐ Yes ☐ No If Yes, hospital name _____

Address: _____ Confined from _____ through _____

CARDIAC *(if applicable) Functional Capacity (American Heart Association)*

☐ Class 1 (No limitations) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Blood Pressure (last reading) _____/_____ as of _____ Date

PHYSICAL IMPAIRMENT *(*as defined in Functional Dictionary of Occupational Titles)*

☐ Class 1 - No limitation of functional capacity, capable of heavy work*No restrictions (0-10%)
☐ Class 2 - Medium manual activity*(15-30%)
☐ Class 3 - Slight limitation of functional capacity, capable of light work* (35-55%)
☐ Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (Sedentary*) activity (60-70%)
☐ Class 5 - Severe limitation of functional capacity, incapable of minimal (Sedentary*) activity (75-100%)
☐ Remarks _____

MENTAL/NERVOUS IMPAIRMENT *(if applicable)*

List the patient's DSM-IV Axes:

Axis I_____ Axis II_____ Axis III_____ Axis IV _____

List the patient's most recent GAF Score_____ Date of assessment_____ Highest GAF Score in the last year _____

Please fully describe the patient's limitations _____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

PROGNOSIS

What are the patient's current restrictions and limitations? _____

	PATIENT'S JOB:	**ANY OTHER WORK:**
If none, when was patient able to resume work?	Month_____ Day_____ Year_____	Month_____ Day_____ Year_____
Do you expect a fundamental or marked change in the future including improvement and/or deterioration?	☐ Yes ☐ No	☐ Yes ☐ No
When will patient recover sufficiently to perform duties?	☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Indefinitely ☐ Never	☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Indefinitely ☐ Never

REHABILITATION

Is patient a suitable candidate for further rehabilitation services? ..... ☐ Yes ☐ No Explain under REMARKS.
(i.e., cardiopulmonary program, speech therapy, etc.)
Would job modification enable patient to work with impairment? ..... ☐ Yes ☐ No Explain under REMARKS.
Would vocational counseling and/or retraining be recommended? ..... ☐ Yes ☐ No Explain under REMARKS.

REMARKS

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

Name of Physician Completing This Form (Print)		Degree/Specialty	Tax ID Number
Address	City	State	Zip Code
Telephone Number	Fax Number		
Signature			Date