AMERICAN GENERAL

Notice of Claim for Short Term Disability Benefits

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

New York, New York
A member company of American International Group, Inc.
Administrative Office: American General Claims Center, P.O. Box 25, Bloomfield, CT 06002-0025

POLICY NUMBER: CERTIFICATE NUMBER: CLASS:

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.

EMPLOYEE'S STATEMENT. . . (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

NAME OF EMPLOYEE | MALE ☐ FEMALE ☐ | EMPLOYEE'S SOCIAL SECURITY OR I.R.S. NUMBER

EMPLOYEE'S ADDRESS STREET & NO. CITY STATE ZIP | TELEPHONE NO. | DATE OF BIRTH MO. DAY YR.

DATE ACCIDENT OR SICKNESS BEGAN | DATE LAST WORKED | DATE FIRST TREATED

NATURE OF SICKNESS OR INJURY | IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN? DID ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐

PHYSICIAN'S NAME AND ADDRESS FIRST CONSULTED FOR THIS CONDITION | LIST NAME AND ADDRESS OF YOUR FAMILY PHYSICIAN

NAME AND ADDRESS OF HOSPITAL, IF CONFINED | DATES OF CONFINEMENT IN OUT

Are you entitled to Benefits from any of the following for this disability?
☐ Workers' Compensation ☐ Salary Continuance ☐ Local, State or National Association or Society Disability Income Plan ☐ No Fault
☐ Social Security ☐ Any Government Agency ☐ None

IF "YES" INSERT POLICY NUMBER, NAME AND ADDRESS OF INSURANCE COMPANY OR ORGANIZATION PROVIDING SUCH BENEFITS OR SERVICES.

POLICY NO. NAME AND ADDRESS

POLICY NO. NAME AND ADDRESS

To all physicians and other medical professionals, hospitals and other medical-care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators:

You are authorized to provide The United States Life Insurance Company in the City of New York (USL) and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on USL's behalf, with information concerning medical care, advice, treatment or supplies provided the Patient, including information relating to mental illness and drug abuse or alcoholism, and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administrating claims for benefits.

I understand that this authorization is valid for the duration of my claim for benefits under USL's policy.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

_______________ SIGNATURE OF EMPLOYEE _______________ DATE

EMPLOYEE'S OR ADMINISTRATOR'S STATEMENT. . . (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

NAME OF EMPLOYEE | OCCUPATION | IS DISABILITY DUE TO EMPLOYMENT? Yes ☐ No ☐ | NUMBER OF HOURS WORKED PER WEEK | SALARY $ ☐ Per Week ☐ Per Month

DATE EMPLOYED MONTH DAY YEAR | DATE INSURED MONTH DAY YEAR | DATE LAST WORKED MONTH DAY YEAR | REASON FOR STOPPING WORK ☐ Dismissed ☐ Lv of Absence ☐ Disability ☐ Resigned ☐ Retired ☐ Layoff

DATE RETURNED TO WORK ☐ FULL-TIME MO. DAY YR. ☐ PART-TIME MO. DAY YR. | IF PART-TIME, HOURS PER ☐ DAY ☐ WEEK *Please attach supporting documents to show part-time earnings | IF EMPLOYEE HAS NOT RETURNED TO WORK, APPROXIMATE RETURN TO WORK DATE MONTH DAY YEAR | DATE EMPLOYMENT TERMINATED MONTH DAY YEAR | DATE INSURANCE TERMINATED MONTH DAY YEAR

PREMIUM CONTRIBUTION PERCENTAGE EMPLOYER _____% EMPLOYEE _____% | IF EMPLOYEE CONTRIBUTES TOWARDS THE COST OF DISABILITY COVERAGE, PLEASE INDICATE IF BEFORE ☐ OR AFTER ☐ INCOME IS TAXED.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

_______________ NAME OF POLICYHOLDER (COMPANY) _______________ PRINT NAME & TITLE OF OFFICIAL REPRESENTATIVE

_______________ MAILING ADDRESS OF POLICYHOLDER (COMPANY) _______________ SIGNATURE DATE

_______________ TELEPHONE NUMBER

DOCTOR'S STATEMENT

(Please Print or Type)

THE DOCTOR'S STATEMENT MUST BE FILLED IN COMPLETELY BY A PHYSICIAN.

Claimant's Name ______________________________ **Age** ________ ☐ **Male** ☐ **Female**

FIRST *MIDDLE* *LAST*

1. HISTORY
   a) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" state when and describe
   (b) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
   ____
   (c) Names and addresses of other treating physicians ______________________________
   ____
   ____

2. DIAGNOSIS
   (a) Diagnosis (including any complications) ______________________________
   (b) Subjective symptoms ______________________________
   ____
   (c) Objective findings (Including current X-rays, EKG's, Laboratory Data and any clinical findings) ______________________________
   ____
   ____

3. For pregnancy disability only:
   Are there any present complications or anticipated difficulties in connection with:
   (a) Pregnancy ☐ Yes ☐ No
   (b) Delivery ☐ Yes ☐ No
   (c) Post Partum ☐ Yes ☐ No
   If yes to any of the above, please specify in detail: ______________________________
   ____
   ____
   ____

4. Enter dates for the following:

	MONTH	DAY	YEAR
(a) Date symptoms first appeared or accident happened			
(b) Date patient was unable to work because of disability			
(c) Date of your first treatment for this disability			
(d) Date of your most recent treatment for this disability			
(e) Frequency of treatment ☐ Weekly ☐ Monthly ☐ Other (Specify)			
(f) Date claimant will be able to perform usual work (even if considerable question exists, estimate date) ☐ Full-Time			
☐ Part-Time			
(g) For pregnancy disability only, expected date of delivery			

5. NATURE OF TREATMENT (including Surgery and medications prescribed, if any)
   ____
   ____
   ____

6. PROGRESS
   (a) Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
   (b) Is patient ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
   (c) Has patient been hospital confined? ☐ Yes ☐ No If "Yes", give Name and Address of Hospital
   ______________________________ Confined from ____________ through ____________

7.
   ATTENDING PHYSICIAN'S SIGNATURE ______________________________ DATE ____________

   PHYSICIAN'S NAME (PLEASE PRINT) ______________________________ DEGREE ________ TEL. NO. ____________

   OFFICE ADDRESS ______________________________

   NUMBER *STREET* *CITY OR TOWN* *STATE* *ZIP CODE*