Critical Illness Benefit Claim Form

American General Life Insurance Company, P O Box 1500, Nashville, TN 37202-1500
A member of American International Group, Inc. (AIG)

PART A - To be completed by Insured

Insured/Patient must complete form 2118D to Obtain and Disclose information to expedite the claim process.

Name of Insured ______________________________
Policy Number______________________________
Insured's Date of Birth ______________________
Claimant/Owner's Name, Address, and Phone No.
Name ______________________________
Street ______________________________
City______________ State _____ Zip Code ________
Phone No. (____) __________________

****SEE DEFINITION IN POLICY FOR THE CONDITION YOU SELECT****

____Invasive Cancer
____Kidney (Renal) Failure
____Coma
____Major Organ Transplant
____UNOS Advance Benefit*
(see endorsement)
____Severe Burn
____Loss of Sight, Speech or Hearing
____Loss of Independent Living
____Health Screening (attach proof of type of screening)
____Medical Personnel HIV Benefit*
*(Rider must be present)

____Heart Attack
____Stroke
____Coronary Artery Bypass
____Paralysis
____Quadriplegia
____Paraplegia
____Hemiplegia
____In Situ Cancer
____Dismemberment Rider
(Form 183 required)
____Return of Premium
____Benefit Extension Rider

Names and addresses of all physicians or practitioners and all hospitals or institutions by whom or in which you have been attended, treated or examined during the last five years.

NAMES	ADDRESSES	DATES OF ATTENDANCE	DISEASE OR CONDITION

---------- Payment of Policy Proceeds ----------

If your insurance benefit is $50,000 or more, you may elect to have the proceeds paid through a free, interest-bearing account called the Convenience Benefit Account®. (This option is not available for residents of Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York.)

- This is a draft account whereby you may draw down the insurance proceeds and interest by drafting drafts which are payable through State Street Bank and Trust Company.
- A personal draft book will be mailed to you once your claim has been approved. You may access your account by writing a draft for $250.00 or more. If you wish, you can write a single draft for the entire amount, including interest, to close your account. Your drafts are payable through State Street Bank and Trust Company. The delivery of your draft book constitutes payment of your full benefit amount.
- There are no monthly service charges, per-draft charges or draft fees. Fees will be charged for the following special services: any draft presented for payment against insufficient funds, any stop payment order, and any draft or statement copies. The charging bank reserves the right to change its fees at any time.
- Should your Convenience Benefit Account balance drop below $10,000, the account will be automatically closed and a draft for the balance mailed to you, with accrued interest on the 10th day of the following month.
- You will receive a monthly statement, showing all transactions, interest credited and the applicable rate(s) of interest for the period.
- Your Convenience Benefit Account earns interest at 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. There is not a minimum interest rate credited to the account.
- Interest is compounded daily and credited to your account monthly. Interest may be taxable; please consult with your tax advisor regarding taxable interest amounts.
- To obtain the current interest rate for your account, please review your monthly statement or call 1-800-888-2402.
- Both your principal and any interest you earn are guaranteed by American General Life Insurance Company (American General Life).
- The Convenience Benefit Account is not insured by the Federal Deposit Insurance Corporation (FDIC). Its funds are guaranteed by the State Guaranty Associations. Please contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about coverage of your account.
- Account balances are the liability of American General Life, and American General Life reserves the right to reduce account balances for any payment made in error.
- Settlement options under any policy for which benefits are paid under a Convenience Benefit Account are preserved until the entire Convenience Benefit Account is withdrawn or the balance drops below $10,000.00.
- If an initial life insurance benefit is less than $50,000, American General Life will send you a check for the total benefit amount.
- Any value remaining in your Convenience Benefit Account may be transferred to the appropriate state authority as unclaimed property if no activity occurs in the account within the time period specified by applicable state law.

If you have questions regarding the Convenience Benefit Account, please call 1-800-888-2402 or write to American General Life Insurance Company, 366S American General Center, Nashville, TN 37250. For all other claim related questions, please call 1-800-888-2452.

Select one of the following choices:

☐ Please pay the insurance proceeds through the Convenience Benefit Account **(Not available if you are a resident of Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York)**.

☐ Please pay the insurance proceeds by check.

If you do not select one of the options above for payment, any proceeds payable will be paid by company check.

Note: The signature on this Claimant's Statement will be used as your signature card for the Convenience Benefit Account.

X
Signature

Date______________________

Important Notice

In some states we are required to advise you of the following: Any person who knowingly intends to defraud or facilitates a fraud against an insurer by submitting an application or filing a false claim, or makes an incomplete or deceptive statement of material fact, may be guilty of insurance fraud.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 and 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 provided false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the 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.

Delaware, Oklahoma, Idaho, Indiana: WARNING - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia, Maine, Tennessee, Virginia, Washington: WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject 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.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

ALL OTHER RESIDENTS: A law of your state requires us to inform you that 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.

Owner's Certification of Social Security Number/Taxpayer Identification Number

IRS Certification: Under penalties of perjury, I certify that: (1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: _____), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. citizen or other U.S. person*, and (4) The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: _____).** Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you are a U.S. citizen or U.S. resident alien, FATCA reporting does not apply to you.

Social Security Number/Taxpayer Identification Number ____________________

I understand that no insurance agent of the Company is authorized to make any claim decision or any representation as to whether any claim should or will be paid.

I agree to cooperate with the Company in its investigation of this claim by providing assistance including, but not limited to, completing, signing, and submitting any questionnaire or authorization form needed by the Company, in its sole opinion, to conduct its investigation.

The Internal Revenue does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

X

Signature of Owner

Date____________________

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

PART B - Attending Physician's Statement

When did symptoms first appear or accident happen? Date: ______________________________

Was condition due to: _______disease ________injury

Diagnosis Code: ____

Diagnosis Detail: ____

(if loss of sight list the ____

central vision in each eye ____

____

Has patient ever had a same or similar condition? _______Yes (explain) _______No

____

____

____

Duration of Coma based on your knowledge of patient's background. (If claiming Coma Benefit)

______1-3 Months _______3-6 Months _______6-12 Months ______More than 12 months

Loss of Independent Living Benefit Claims-Select the activities of daily living that the insured is **permanently** unable to perform:

(See definition of each activity in the policy contract)

_____Bathing ______ Transferring

_____Dressing ______ Continence

_____Toileting ______ Eating

Additional Remarks: ____

____

____

____

____

____

____

____

Doctor's Name ____Date ______________________

Street ____

City________________________________ State ________ Zip Code ____________ Phone No.(______) ______________

X

Doctor's Signature

Doctor's License # ____________________ NPI # ____________________

If hospitalized as a result of this condition:

Hospital Name ____ NPI # ____________________

Street ____

City________________________________ State ________ Zip Code ____________ Phone No.(______) ______________

Admission Date: ______________________________Discharge Date ______________________________