Life Insurance Policy Claim

Losing a loved one is one of the most difficult life events we ever have to face. At this emotional time of grief and remembrance, financial and legal issues must also be addressed - a process that can seem overwhelming. Fortunately, you and your loved one established life insurance policies to provide your family with the support they need in this stressful time.

What documentation do I need to submit?

Refer to the cover letter that we sent you with your claim packet for the specific documentation that as a Beneficiary you need to submit. This form is the Claimant Statement.

Instructions / Checklist on completing documentation.

☐ **Claimant Statement, page 2.**

- Complete all information concerning the deceased and claimant / beneficiary.
- Indicate multiple policy numbers if you are the beneficiary for multiple policies, as one form can be used for all policies. If unsure of Claim #, this can be left blank.
- Each claimant / beneficiary must complete their own form.
- If you have assigned part of the proceeds of a policy for payment, please provide each assignee name and contact number.
- Sign and date the Fraud Disclosure Statement on page 2 indicating you are aware of the fraud language provided.
- Complete the Certification of Trustee section ONLY if a Trust is the beneficiary. Provide the date of the trust, and if amended since time of the beneficiary designation please provide that information.
- Spouses: for Federal tax law and ERISA purposes, under current IRS and DOL guidance (1) a same-sex marriage that was valid in the state or country it was entered into will be recognized by the IRS and /or DOL, regardless of the married couple's place of domicile; and (2) although a state may recognize domestic partnerships or civil unions, the terms "spouse," "husband and wife," "husband" and "wife" do not include individuals who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

☐ **Payment of Policy Proceeds, page 3.**

- Read the important information on the Instant Access Account option if your benefit is $50,000 or more. *(This option is not available for residents of Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York.)*
- Only mark one of the payment options from the selections provided.
- Sign and Date your election.

☐ **Withholding Elections for Tax, page 4.**

- Complete the withholding election.
- Sign and Date this page.

☐ **Accidental Deaths, Homicides or if the policy has been in force less than two years, page 5.**

- If the policy had accidental death benefits and the manner of death was accidental, please complete the top section of page 5; otherwise leave blank.
- If the manner of death was homicide, please complete the section on page 5 by providing details of the case; otherwise leave blank.
- If the policy is less than two years old, please complete the bottom section of page 5; otherwise leave blank.

☐ **Complete and sign the HIPAA Authorization form, page 8.**

- Read and retain the Fraud Warning Disclosure, and MIB, LLC Notice. These are the last two pages.

"If you have any questions or need assistance with completing the Claimant Statement, please contact a customer service representative at 1.844.452.3832 (M-F) 7:00AM to 6:00PM Central Time."

Proof of Death
Claimant's Statement

☐ **American General Life Insurance Company**
☐ **The United States Life Insurance Company in the City of NY**

Mail to: PO Box 818100, Cleveland, OH 44181
Overnight: Corebridge Financial - Production #2, 5575 Venture Drive, Unit D/Dock Door 21, Parma, Ohio 44130 - Note: use only UPS/FedEx. Do not overnight with USPS.

To Be Completed By Each Beneficiary *(please print)*				Claim Number
POLICY NUMBER/GROUP NUMBER & CERTIFICATE NUMBER (If multiple policies, please list all)				
DECEASED FULL NAME (include middle name)		DECEASED SOCIAL SECURITY NUMBER		DATE OF BIRTH
CAUSE OF DEATH	DATE OF DEATH	List other hyphenations, nicknames, aliases and/or maiden names used by deceased in the past.		
CLAIMANT'S NAME		DATE OF BIRTH		SOCIAL SECURITY # OR TIN
ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO DECEASED
EMAIL ADDRESS		TELEPHONE NO. ( )		ALT NO. ( )

Have you assigned any of the proceeds of this policy to a Funeral Home? ☐ Yes ☐ No If yes, who have the proceeds been assigned to?_____
(If assigned, we must have the assignment papers to process the claim, please provide a copy of the Funeral Home assignment.)

LIST EACH ASSIGNEE WITH CONTACT NUMBER

I have read and I understand the important Fraud Disclosure information located on page 6 of this form. 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.

AUTHORIZATION REGARDING_____ ("Insured")

I, the Claimant / Legal Representative of the Insured authorize each insurance company listed above (collectively, the "Company") and their authorized representatives including their employees and agents, to provide information to, and, to receive information from, MIB, LLC, which operates an information exchange that assists insurance companies with benefit administration, claims, and fraud prevention and detection activities. The authorization will be valid for the duration of the claim or 24 months, whichever is longer. I understand that I may revoke it by giving written notice to the Company, but any action taken by the Company before receipt of such notice will be valid. I acknowledge that I am entitled to obtain a copy of the authorization and a copy will be as valid as the original.

PLEASE SIGN HERE _____
Signature of Claimant/Legal Representative of the Insured

_____ _____
Printed Name Date

Certification of Trustee(s) complete this section only if Beneficiary is the Trust

Name of Trust: _____

Tax ID of Trust:_____

The undersigned hereby certify as follows:
1. That they are Trustees under a Trust Agreement dated: _____ Amended: _____
2. That they are the Trustees designated as beneficiary under the above numbered policy(ies);
3. That said Trust Agreement is in full force and effect and that by its terms they are empowered to receive payment of the proceeds of the above policy(ies);
4. That, if applicable, said Trust/Plan is presently fully qualified having met the requirements of Section 401(a) of the Internal Revenue Code.

It is understood and agreed by the undersigned that payment of such proceeds to the Trustees shall discharge the Company from any and all liability therefore and that the Company shall have no responsibility for the carrying out of the Trust Agreement.

The plural as used herein shall include the singular wherever applicable.

Signed this_____ day of _____ 20 _____ .

Individual Trustee(s): _____ _____
(Trustee Signature) (Printed Name)

_____ _____ _____ _____
(Signature) (Printed Name) (Signature) (Printed Name)

OR

Corporate Trustee: _____
(Name of Corporate Trustee)

By: _____ _____ _____
(Officer's Signature) (Printed Name) (Title)

(All co-trustees must sign.)

------- 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 Instant Access 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 The Bank of New York Mellon.
- 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 The Bank of New York Mellon. 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 Instant Access 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 Quarterly statement, showing all transactions, interest credited and the applicable rate(s) of interest for the period.
- Your Instant Access 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 Quarterly statement or call 1-888-562-9158 (M-F) 8 AM - 7 PM Eastern Time.
- Both your principal and any interest you earn are guaranteed by American General Life Insurance Company (American General Life).
- The Instant Access 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 Instant Access Account are preserved until the entire Instant Access 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 Instant Access 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 Instant Access Account, please call 1-888-562-9158 (M-F) 8 AM - 7 PM Eastern Time or write to Instant Access Account, P.O. Box 534025, Pittsburgh, PA 15253-4025.

Select one of the following choices:

- ☐ Lump sum payment - the death benefit is paid in a single lump sum settlement check.
- ☐ Proceeds left at interest - proceeds left on deposit with us earning interest at a rate we determine or at a rate specified in the contract if a higher rate is shown.*
- ☐ Instant Access Account - the death benefit is left on deposit with us earning interest at a rate we determine. The funds are accessible through an Instant Access Account, as described above.
- ☐ Payments for a specific period - you will receive equal monthly payments for a specific period you select. The number of payments you wish to receive is:_____ (in months).*
- ☐ Payments for a specific amount - you will receive equal monthly payments of an amount you selected until the death benefit, and any accrued interest, is paid in full. The amount of each payment you wish to receive is: $_____ .*
- ☐ Payments for life - you will receive equal monthly payments for your life. Upon your death, payments will cease.
- ☐ Payments for life with a guaranteed period - you will receive equal monthly payments for at least the guaranteed period* and payments will continue beyond that period until your death.

*Any amount remaining upon your death would be paid according to the beneficiary designation established for the payments.

If you elect a repetitive payment option (monthly payments) we will need an updated withholding election that we will send to you after we receive this Claimant Statement.

Payment Mailing – provide the address to which lump sum check payments should be sent if different from the claimant address provided on page 2. In this section you can provide the policy's active Servicing Agent information for the Company to mail the check to your Agent.

_____

Name/Address (Include business/entity name of address, if applicable) City State Zip

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 Instant Access Account, if selected.

_____ Date: _____

Signature

Federal and State Income Tax Withholding:

Generally, under current federal tax law, the death benefit of a life insurance policy is not subject to federal income tax to the beneficiaries. There are exceptions related to transfers for value of a life insurance policy during the life of the owner/insured. However, any interest provided associated with a death benefit payment is subject to taxation and will be tax reportable annually. This interest on the death benefit amount, if applicable, will be determined when the claim is paid according to policy provisions and state interest requirements.

If your state requires mandatory withholding, we will withhold the mandatory amount without regard to your election below. **Should your state of domicile require a specific state withholding form, your state income tax withholding election will not be taken into account (and we will withhold based on the state mandatory withholding rate) until the required form is received at our Service Center.**

Withholding Election *(must be completed)* — If you are eligible to elect out of and elect not to have federal or state income tax withheld, please be advised that you may be liable to pay the federal or state income tax on your payment(s) as deemed appropriate by the IRS or state taxing authority, regardless of your election. You may also be subject to tax penalties if your payments of estimated tax and withholding, if any, are not adequate. If at any point in time after submitting this form you would like to change your tax withholding election, please send us an updated Form.

Federal Withholding Election	**State Withholding Election**
☐ **DO NOT** withhold any federal income taxes unless mandated by law. ☐ **DO** withhold federal income taxes in the amount of $ _____ or _____ % (cannot be less than any mandatory withholding).	☐ **DO NOT** withhold any state income taxes unless mandated by law. ☐ **DO** withhold state income taxes in the amount of $ _____or _____ % (cannot be less than any mandatory withholding). The following states do not allow withholding: Alaska, Florida, Nevada, New Hampshire, South Dakota, Tennessee, Texas, Virgin Islands, Washington, Wyoming.

Notice to non-resident aliens: A payment to a non-U.S. person/entity may be subject to federal income tax withholding at a rate of 30% of the taxable portion (the interest on the death benefit, if applicable), unless the payee submits a completed IRS Form W-8BEN (or if applicable, a Form W-8BEN-E) and the payment is eligible for reduced federal income tax withholding. If the payee is an entity, it will be considered a foreign entity and subject to a mandatory 30% federal tax withholding of the gross payment until a completed Form W-9 showing that it is a U.S. entity or a Form W-8 (of some variety) is provided.

The Company will provide you and the Internal Revenue Service with an informational tax form after the close of the calendar year.

Tax Certification

The payment(s) you receive may be subject to federal income tax withholding unless we *have your correct US Taxpayer Identification Number [TIN] in the associated substitute Form W-9*. T**he Company will withhold 24% of the interest portion, if applicable, on the death benefit payment(s) as a default, unless the below certification is completed and returned to the Company. Even if you return this form, the proceeds will be subject to the 24% withholding if the IRS has notified the Company that you are subject to Backup Withholding.**

TAX CERTIFICATION (Substitute Form W-9) – Applicable to U.S. persons (including U.S. citizens and resident aliens). If you are not a U.S. person, you are required to submit the applicable IRS Form W-8 series (BEN, BEN-E, ECI, EXP or IMY).

Under penalties of perjury, I certify to the following:

1. That the taxpayer identification number listed on this form is my correct SSN/TIN and I am a U.S. Citizen or other U.S. person (including resident aliens);
2. I further certify that I am exempt from and have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding. The Company is required to withhold income tax on any payments, which include interest and dividends when the owner is subject to backup withholding.; and
3. I am exempt from Foreign Account Tax Compliance Act ("FATCA") reporting.

Certification Instructions: You must cross out any statement in 1-3 that does not apply to you. For any instructions on how to complete this certification, please see the General Instructions for the IRS Form W-9 on www.irs.gov. If you can complete a Form W-9 (Request for Taxpayer Identification Number) and you are a U.S. Citizen or U.S. resident alien, FATCA reporting may not apply to you. **Please consult your own tax advisor with any questions you may have regarding this certification.**

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

Claimant / Beneficiary Signature (Required)

Date (Required) _____

If You Are Claiming Any Accidental Death Benefits

Please complete this section: (Include copies of available newspaper clippings and/or police report giving circumstances)
Type of Accident:

_____

Date: _____ Location: _____

Details: _____

_____

_____

_____

Investigating Officer/Agency:

Name: _____

Address: _____

Phone Number: _____

If Manner Of Death Was Homicide

Motive? _____ Arrest Made? ☐ Yes ☐ No

Suspects? (Give names) _____

Trial pending? ☐ Yes ☐ No

Witnesses? (Give names, addresses, phone numbers)

_____

Investigating Officer/Agency:

Name: _____

Address: _____

Phone Number: _____

If Policy Has Been In Force For Less Than Two Years, please complete this section:

Please provide a statement of medical history for the deceased. Include Name, Address, Phone Number and year of treatment for all Doctors, Hospitals, and Clinics that had treated the deceased in the last 10 years. Also, include the name of the Pharmacy and Group Insurance Carrier. If additional space is needed please include a separate page if necessary.

The Company Will Order These Records.

Health or Member ID No.: _____

Carrier: _____

Address: _____

_____

Phone Number: _____

Insured: _____

Pharmacy: _____

Address: _____

_____

Phone Number: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Year of Treatment: _____

Doctor/Hospital: _____

Address: _____

_____

_____

Phone Number: _____

Year of Treatment: _____

Year of Treatment: _____

>>>Please detach & keep page.<<<

FRAUD WARNING DISCLOSURE

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, Rhode Island, 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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 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: 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: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

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 Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

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.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years.

Tennessee, Virginia & Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.

MIB, LLC NOTICE

Information regarding your insurability or claim will be treated as confidential. The Company, or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB) which operates an information exchange on behalf of its Members of MIB Group, Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information from its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for the life or health insurance, or, to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

The licensed insurance company is responsible for its own financial condition and contractual obligations. AGL is not licensed to do business in the state of New York.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

_____ ____/____/____

Name of Insured (Please Print) **Date of Birth**

I, the Insured above or the Personal Representative acting on behalf of the Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated services company (AGL, US Life and affiliated services companies 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 Insured's health (except psychotherapy notes) and the Insured'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; drug prescriptions, and communicable diseases including HIV or AIDS; and
- Information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities to provide the information outlined above to:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above) which may have provided the Insured with life, accident, health, and/or disability insurance coverage, or to which the Insured may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- the Insured's employer, group policy holder, or benefit plan administrator;
- MIB, LLC (MIB); and
- _____

I understand that the information obtained will be used by the Recipient to:

- determine the Insured's eligibility for benefits under and/or the contestability of an insurance policy; and
- detect 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 Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the 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: American General Life Insurance Company, Attn: Life Claims Department, P.O. Box 818100, Cleveland, OH 44181. I understand that my revocation of this authorization will not affect uses and disclosure of the Insured's health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under the Insured's 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 information necessary to consider a claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under the Insured's 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, upon request, a copy of this authorization.

MIB ACKNOWLEDGEMENT

I also authorize the Company, its reinsurers or authorized third party administrators to make a brief report to MIB.

_____ _____

Printed Name of Insured or Personal Representative | Policy Number/ Control Number

x _____

Signature of Insured or Insured's Personal Representative | Date

_____ _____

Printed Name of Witness | Relationship

x _____

Witness Signature (if required) | Date

_____

Description of Authority of Personal Representative