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?

The following should be submitted as part of filing a death claim.

- Claimant's Statement (enclosed)
- A Certified Death Certificate for the insured indicating cause or manner of death.
- The Obituary or Newspaper Article concerning the death, when available.
- The original contract, if available. If you are unable to locate the contract, please note that on the top of your claimant statement.
- A completed HIPAA Authorization (enclosed).

Special Instructions

- Estate Beneficiary: The claimant statement must be completed by the Executor or Administrator, and a certified copy of their appointment must be furnished.
- Minor Beneficiary: The claimant statement is to be completed by the legally appointed guardian of the Estate of the minor and a certificate of the guardian's appointment from the court must be furnished.
- Predeceased Beneficiary: When a beneficiary has predeceased the insured, a copy of their death certificate must be furnished.
- · Class Beneficiaries: (Example "Children", "Heirs") An affidavit showing the names and dates of birth of each must be submitted.
- Assignee: A Statement must be completed by the assignee. If the assignment is no longer effective, a release of assignment from the assignee
 must be submitted. If collaterally assigned, the statement must be completed by both the beneficiary and the assignee and the amount claimed
 by the assignee indicated on the statement.
- Business Beneficiaries: If the beneficiary is a business, the person signing the claimant statement must be an officer/owner of the company. The
 company name must be given and the title of the person signing. Example: John Doe Auto Sales, Pat Jones, President. You must also include
 documents supporting that the person signing the claim form has the authority to do so. Example: Corporate resolution, official board minutes, etc.
- Death Outside the USA: For USA citizens, a Certified death certificate must be accompanied by a "Report of Death of a U.S. Citizen or U.S. Non-Citizen National Abroad" report from the U.S. Department of State.
- 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.

Instructions / Checklist on completing documentation.

☐ Claimant Statement

- 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 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.

Payment of Policy Proceeds

- 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

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

Accidental Death, Homicide, Contestable Policy, Contestable Policy Segment, or Formally Reinstated Policy.

- If the policy had accidental death benefits and the manner of death was accidental, please complete the section titled If You Are Claiming Any Accidental Death Benefits; otherwise leave blank.
- If the manner of death was homicide, please complete the section titled If Manner Of Death Was Homicide; otherwise leave blank.
- If the policy or any insurance coverage segment within the policy has been in force less than two years preceding the deceased's death, please complete the section titled *If Policy or any Insurance Coverage Segment Therein Has Been In Force For Less Than Two Years or Formally Reinstated in the Two Years preceding the Decedent's Death*; otherwise leave blank.
- If the policy was formally reinstated by means of a written, underwritten application within the two years preceding the deceased's death, please complete the section titled *If Policy or any Insurance Coverage Segment Therein Has Been In Force For Less Than Two Years or Formally Reinstated in the Two Years preceding the Decedent's Death*; otherwise leave blank.
- Complete and have the deceased's Personal Representative sign the HIPAA Authorization form. A deceased's Personal Representative is
 an executor, administrator, or other person who has authority under applicable State or other law to act on behalf of the deceased or the
 deceased's estate.

L	Read and retain t	he Fraud Warning	Disclosure, and MIB	, LLC Notice. 7	Γhese 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 1.877.800.2418 (M-F) 7:00AM to 6:00PM Central Time.

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

Mail to: PO Box 818008 Cleveland, OH 44181 Overnight: Note: use only UPS/FedEx. Do not overnight with USPS.

Corebridge Financial - Production #1 5575 Venture Drive, Unit D/Dock Door 21 Parma, Ohio 44130

Proof of Death Claimant's Statement

To Be Completed By Eac	ch Beneficiary (please p	rint)					
Claim Number	Policy Nu	mber/Group Number & Certi	ficate Number (If n	nultiple policies, pl	ease list all)		
Deceased Full Name (incl.	ude middle name)		Decease	ed Social Security	Number	Date of Birth	
Cause of Death	Date of Death	List other hyphenations, ni	icknames, aliases ar	nd/or maiden name	es used by de	eceased in the past.	
Claimant's Name			Social S	ecurity # or TIN		Date of Birth	
Address		City	State	Zip	Relation	nship to Deceased	
Email Address			Telephor	Telephone Number A		Alt. Telephone Number	
		ey to a Funeral Home? Yet to process the claim, please		he Funeral Home .	assignment	.)	
If yes, who have the proce	eds been assigned to? _						
List each assignee with co	ontact number						
knowingly and with intent t any materially false inform	to defraud any insurance of ation, or conceals for the	d Disclosure information locompany or other person file purpose of misleading, inforubject to a civil penalty not to	s an application for mation concerning	insurance or state any fact material t	ement of cla hereto, com	aim containing mits a fraudulent	
I, the Claimant / Legal Rep authorized representatives operates an information ex activities. The authorizatio	presentative of the Insured is including their employee schange that assists insur n will be valid for the dura any, but any action taken	d authorize each insurance of and agents, to provide informance companies with benefit ance companies with benefit ation of the claim or 24 month by the Company before receive as valid as the original.	company listed abover formation to, and, to t administration, cla ns, whichever is lon	receive information ims, and fraud preger. I understand	on from, MIB evention and that I may re	B, LLC, which d detection evoke it by giving	
Signature of Claimant/Leg	al Representative of the I	nsured				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:	
That they are Trustees under a Trust Agreement dated:	Amended:
2. That they are the Trustees designated as beneficiary under the above	e numbered policy(ies);
 That said Trust Agreement is in full force and effect and that by its term policy(ies); 	ns they are empowered to receive payment of the proceeds of the above
4. That, if applicable, said Trust/Plan is presently fully qualified having n	net the requirements of Section 401(a) of the Internal Revenue Code.
It is understood and agreed by the undersigned that payment of such procee therefore and that the Company shall have no responsibility for the carrying	
The plural as used herein shall include the singular wherever applicable.	
Date Signed	
Individual Trustee(s)	
Trustee Signature	Printed Name
Trustee Signature	Printed Name
Trustee Signature	Printed Name
or	
Corporate Trustee	
Name of Corporate Trustee	
Officer's Signature	Title
Printed Name	<u> </u>
(All co-trustees must sign.)	

Pav	/ment	٥f	Policy	/ Proce	2hac
Iay	/1110111	UΙ	I UIICY		ะตนว

Signature

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. Note: On IRAs, payments for life are only available to Eliqible Designated Beneficiaries (EDB's.) Additionally, the guaranteed period cannot exceed 10 years unless you are an EDB. 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. Zip Name/Address (Include business/entity name of address, if applicable) City State 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.

Page 4 of 9

Date

Tax Withholding Disclosures - Life Insurance Policies Only

Federal Income Tax Withholding of the Death Benefit: The death benefit distribution(s) you receive from the Company may be subject to federal income tax withholding unless you are eligible to elect out of withholding on a Form W-4P or Form W-4R (as applicable) or below, and thereby not have withholding apply. (Note: We must have your correct U.S. Taxpayer Identification Number [TIN] in order for you to elect into or out of withholding.) Withholding will only apply to the taxable portion of your distribution. Your withholding election will remain in effect until you revoke it. The Company will withhold 10% of the taxable amount for non-periodic payments or for periodic payments, the Company will withhold based on the current wage withholding default of single with no adjustments, unless you elect otherwise on a Form W-4P or Form W-4R (as applicable) or below.

Federal Income Tax Withholding of any interest associated with the death benefit (if applicable): Any interest payment you receive associated with a delay in death benefit payment is subject to taxation and will be tax reportable. 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 (Tax certification). The Company will withhold 24% of your interest payment(s) as a default, unless this form is fully 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 Withholding Disclosures - Annuity Contracts Only

The Internal Revenue Code section 401(a)(9) mandates certain distributions from qualified annuity contracts. These are known as Required Minimum Distributions or RMDs. A nondeductible penalty tax may be imposed on any RMD amount required but not distributed each calendar year. The Company is not responsible for the satisfaction of RMD's. We recommend that you consult with your tax advisor as to your obligations with regard to the distributions from the annuity contract.

The distribution(s) you receive from the Company may be subject to federal income tax withholding unless you are eligible to elect out of withholding on a Form W-4P or Form W-4R (as applicable) or below, and thereby not have withholding apply. (*Note: We must have your correct U.S. Taxpayer Identification Number [TIN] in order for you to elect into or out of withholding.*) Withholding will only apply to the taxable portion of your distribution. Your withholding election will remain in effect until you revoke it. The Company may be required to withhold 20% in federal income tax from the taxable portion of an eligible rollover distribution from qualified retirement plans or 403(b) plans. For an eligible rollover distribution, if you would like to withhold more than 20%, please complete and return a Form W-4R. If mandatory 20% withholding on eligible rollover distributions does not apply, the Company will withhold 10% of the taxable amount for non-periodic payments or for periodic payments, the Company will withhold based on the current wage withholding default of singled with no adjustments, unless you elect otherwise on a Form W-4P or W-4R (as applicable) or below. Spousal beneficiaries receiving eligible rollover distributions from 403(b)s may be subject to 20% mandatory withholding. Spousal beneficiaries receiving distributions from IRAs and nonqualified annuities are not subject to 20% mandatory withholding.

Tax Withholding Disclosures and Election Options - Life Policies and Annuity Contracts

States with a state income tax either require mandatory withholding or allow voluntary withholding. If your state requires mandatory withholding, we will withhold the mandatory amount no matter your election below. If your state allows for voluntary withholding but does not provide a default amount, and you elect state income tax withholding but don't fill in a specific amount or percentage, we will withhold 5% of the taxable portion of your distribution for state income tax purposes. Should your state of domicile require a specific state withholding form, your state income tax withholding election on this form will not be taken into account (and we will withhold based on the state mandatory withholding rate or our default state income tax withholding) until the required form is received at our Customer Service Center. For information regarding your resident state's specific withholding requirements and mandatory withholding percentages (if applicable), please consult with your tax advisor.

Withholding Election – If you are eligible to elect out of and thereby not 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 distribution as deemed appropriate by the Internal Revenue Service 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 our Customer Service Center an updated Form W-4P or Form W-4R, as applicable, to change your federal election. For changes to your state withholding election, you may provide updated elections on a new copy of this form, unless your state requires a specific state withholding form. In which case you must use that specific form. Please consult your tax advisor for further information.

The taxable portion of the distribution(s) will be subject to a default 10% federal tax withholding for non-periodic payments, the current wage withholding default of single with no adjustments for periodic payments or 20% if an eligible rollover distribution, unless you complete and submit a Form W-4P or W-4R (as applicable) with this administrative form or elect out of withholding below.

Lump Sum Distribution Only (Life Insurance or Annuity)

Federal Withholding Election State Withholding Election (Select only one option below) (Select only one option below) ☐ I elect to withhold federal income taxes as indicated on the ☐ I elect not to withhold any state income taxes unless mandated accompanying Form W-4R. The current Form W-4R is available by law. on the IRS website at www.IRS.gov. ☐ I elect to withhold state income taxes in the amount of ☐ I elect to withhold the federal income tax default rate of 10% (or ___ % (cannot be less than any ____ or _ 20% if taking an eligible rollover distribution) from the taxable mandatory withholding). portion of my distribution and will not be providing a Form W-4R. The following states do not allow withholding: Alaska, Florida, ☐ I elect not to withhold any federal income taxes unless mandated Nevada, New Hampshire, South Dakota, Tennessee, Texas, Virgin Islands, Washington, Wyoming. Note – If you check the box above to elect the federal income tax default withholding rate or elect out of withholding and provide the Company with a completed Form W-4R, the Company will utilize the election instructions provided on the Form W-4R.

Life Insurance Death Benefit Settlement Options or Annuity Income Payments Only **Federal Withholding Election** State Withholding Election (Select only one option below) (Select only one option below) ☐ I elect to withhold federal income taxes as indicated on the ☐ I elect not to withhold any state income taxes from my periodic accompanying Form W-4P. The current Form W-4P is available income payments. on the IRS website at www.IRS.gov. ☐ I elect to withhold state income taxes from my periodic income ☐ I elect to withhold the current federal income tax wage payments in the amount of (complete either A or B below): withholding default of single with no adjustments (or 20% if taking Withhold taxes based on: an eligible rollover distribution) from the taxable portion of my (Enter number) Number of Withholding Allowances distribution and will not be providing a Form W-4P. Marital Status (check one): ☐ I elect not to withhold any federal income taxes unless mandated ☐ Single □ Married by law. I want an additional amount withheld of \$_____ (please Note – If you check the box above to elect the federal income tax indicate the dollar amount) default withholding rate or elect out of withholding and provide the Company with a completed Form W-4P, the Company will utilize the The following states do not allow withholding: Alaska, Florida, election instructions provided on the Form W-4P. 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 of the distribution, unless the pavee 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. Notice for payments made outside the U.S. - A payment to a U.S. person/entity and delivered to an address outside the United States and its possessions is subject to the current federal income tax wage withholding default of single with no adjustments for periodic payments, at a rate of 10% for non-periodic payments, or 20% if taking an eligible rollover distribution, and cannot be reduced. The Company will provide you and the Internal Revenue Service with an informational tax form; generally, the form will be provided 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. The 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; and 3. I am exempt from Foreign Account Tax Compliance Act ("FATCA") reporting. Certification Instructions: You must cross out any statement in 1-3 above that does not apply to you. For 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. New York Fraud Notice: Any person who knowingly and with intent to defraud any insurance company The Internal Revenue Service does not or other person files an application for insurance or statement of claim containing any materially false require your consent to any provision information, or conceals for the purpose of misleading, information concerning any fact material thereto, of this document other than the commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to certifications required to avoid backup exceed five thousand dollars and the stated value of the claim for each such violation. withholding. 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 Dea	ath Benefits	
Please complete this section: (Include cop	ies of available newspaper clippings and/or poli	ce report giving circumstances)
Type of Accident		
Date	Location	
Investigating Officer/Agency		
Address		
If Manner Of Death Was Homicide		
Motive?		Arrest Made? ☐ Yes ☐ N
Trial Pending? ☐ Yes ☐ No		
Witnesses? (Give names, addresses, phone	numbers)	
Investigating Officer/Agency		Disco North
		Phone Number
Address		
If Policy or any Insurance Coverage Sethe Two Years preceding the Decedent	egment Therein Has Been In Force For Less's Death, please complete this section.	Than Two Years or Formally Reinstated in
	ry for the deceased. Include Name, Address, Phon ceased in the last 10 years. Also, include the name eparate page if necessary.	
The Company Will Order These Records		
Health or Member ID Number	Carrier	Phone Number
Address		<u> </u>
	Pharmacy	Phone Number
Address	<u> </u>	
Address		
Phone Number	Year of Treatment	
Doctor/Hospital		
Address		
Phone Number	Year of Treatment	
Doctor/Hospital		
	Year of Treatment	
Doctor/Hospital		
Address		
	Year of Treatment	

Fraud Warning Disclosure

Please detach & keep page.

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 quilty 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 Prin	t)	Date	e of E	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 818008, 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		
х			
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			