

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

Name of Patient/Proposed Insured (Please Print)

Date of Birth

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, American General Life Insurance Company, American International Life Assurance Company of New York, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service company), (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; 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:

- any physician or medical practitioner;
- 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 other American General Life Companies company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

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

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life Companies 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 Companies Service Center, P. O. Box 4373, Houston, TX 77210-4373. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Insured or
Insured's Personal Representative

Date

Description of Authority of Personal Representative
(if applicable)

American General

Life Companies

Accident and Health Insurance Claim Form

American General Life Insurance Company (AGL)
P. O. Box 4277, Houston, TX 77210-4277

HOW TO SUBMIT YOUR CLAIM - PLEASE PRINT

STEP 1. Complete Part A, below as it applies to this claim. Date and sign for all claims.

STEP 2. Complete Part B on the reverse side. The authorization to pay benefits to the physician is to be signed if you wish payment to be made directly to the health care provider.

STEP 3. Have your attending physician complete Part C on reverse side.

STEP 4. When you and your attending physician have completed the form, in detail, attach all related itemized medical bills and forward to the company for review and processing.

PART A TO BE COMPLETED BY INSURED

Please Note: Failure to complete this form IN FULL may delay payment of your claim.

I. Complete For All Claims

1. Policyholder Name _____ 2. Date of Birth _____
3. Social Security Number _____ 4. Policy Number(s) _____
5. Home Address _____ 6. Home Phone _____
_____ 7. Office Phone _____
-

II. Complete For Dependent Claims Only

8. Dependent's Name _____ 9. Dependent's Date of Birth _____
10. Relationship: Spouse Son Daughter Other: _____ Residence _____
11. Full time student Yes No If "Yes", and 18 years or older provide name and address of school: _____
-

III. Complete For All Claims

13. Describe condition: _____
14. Was condition cause by patient's employment? Yes No If "Yes" has or will a claim be filed with the worker's compensation carrier? Yes No Result? Accepted Denied Pending
15. Date symptoms first noticed: _____ 16. Date first consulted physician _____
17. Name(s) and address(es) of physician(s) consulted for this condition or any similar related condition: _____

18. Did the injury or illness require hospital confinement? Yes No If "Yes" please provide the name of the hospital and dates confined: _____
19. Is person for whom claim is made covered under any other group health or service plan, or federal medicare program? Yes No
20. If "Yes" is other coverage: Employer Plan Union Plan Private Plan Student Plan Other: _____
A. Insured Member's Name _____ B. Policy/Member No. _____
C. Member's Soc. Sec. No. _____ D. Effective Date _____
E. Name, address, and phone number of insurance company or organization providing benefits or service: _____

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IV. Complete For Accident Claims Only

21. Date of accident _____ 22. Was patient at work when accident happened? Yes No
23. Where did accident happen? _____
24. How did accident happen? _____
-

V. Date and Sign for ALL Claims

25. I/We certify that the above information is true and correct. (If claim for spouse, spouse also must sign.) A photographic copy of this certification shall be considered as effective and valid as the original.

Date

Signature of Spouse

Signature of Policyholder

PART B TO BE COMPLETED BY PATIENT/OR INSURED

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: (OPTIONAL)

I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

Date _____

Signature - Insured Person _____

PART C TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Patient's Name _____ Date of Birth: _____

If patient is a minor,

Policyholder's name also: _____ Policy No.: _____

2. Diagnosis and concurrent conditions: (If diagnosis code other than ICD* used, give name)

3. Pregnancy? Yes No If "Yes" approximate date pregnancy commenced: Date: _____

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

5. Report of Services (or attach itemized bill)* (If previous form submitted to this carrier, you need show only dates and services since last report.)

DATE OF SERVICES	PLACE† OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CODE IF USED RVS** or CPT***	CHARGES
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

†0—Doctor's Office IH —Inpatient Hospital NH—Nursing Home **TOTAL CHARGES** ► \$ _____

H—Patient's Home OH—Outpatient Hospital OL—Other Locations **AMOUNT PAID** ► \$ _____

*ICD — International Classification of Diseases **BALANCE DUE** ► \$ _____

**RVS — Relative Value Studies

***CPT — Current Procedural Terminology (Current edition)

6. Date symptoms first appeared or accident happened. _____

7. Date patient first consulted you for this condition. _____

8. Patient ever had same or similar condition? Yes No If "Yes" when and describe. _____

9. Patient still under your care for this condition? Yes No (If "No" give date your services terminated.) _____

10. Was laboratory work performed outside your office? _____

11. Name of referring physician. _____

12. Patient was hospital confined. Yes No From _____ thru _____

Name of hospital _____

13. Is the person for whom claim is made covered under any other Health/Service plan? Yes No

Medicare? Yes No Med-Cal? Yes No (Med-Cal # _____)

Other Government/Welfare/Aid program? Yes No

DATE _____ SIGNATURE (Attending Physician) _____ TELEPHONE _____

PHYSICIAN'S NAME (Please Print) _____ TAX ID NO. _____ PATIENT'S ACCT. NO. _____

STREET ADDRESS _____ CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

IMPORTANT NOTICE

CALIFORNIA CLAIMANTS: 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 confinements in state prison."

ALL OTHER CLAIMANTS: A law of your state requires us to inform you that any person knowingly and with intent to defraud any insurance company or other persons 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.