LIST POLICY NUMBERS

American General Life Insurance Company

Service Center: PO Box 818100, Cleveland, OH 44181

PART A: STATEMENT FOR DISABILITY BENEFITS (Check appropriate box)

☐ **Disability Income Policy** ☐ **Disability Income Rider (DIR)** ☐ **Cancer Disability** ☐ **Waiver of Premium Rider (PW)**

INSTRUCTIONS TO CLAIMANT: (Claimant's and physician's statements and HIPAA 2118C should be completed to expedite claim process).

Claimant's Name	Employer's Name
	Employer's Address
Residence Address	City / State / Zip Code
City / State / Zip Code	Employer's Telephone Number ( )
	Current Monthly Earnings $_____
Telephone Number ( )	Describe your job/work/business duties and your title when disability began.
Date of Birth Date _____ / Social Security Number	Is condition a result of your employment? ☐ Yes ☐ No
Date Last Worked	Average monthly earnings for the two year period prior to disability $

IF ACCIDENT	IF SICKNESS
a. Describe what injury resulted	Describe nature and details of sickness
b. How did accident happen?	
c. Where did accident happen?	
d. Accident was: ☐ work related ☐ not work related	
e. Date of accident Date _____ ☐ A.M. ☐ P.M.	Date symptoms of illness first appeared Date _____
TREATMENT First treatment by a physician for this condition / /	Doctor's Name and Address
If hospitalized: Admitted / / Discharged / /	
Hospital Name	Hospital Address

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

NAMES	ADDRESSES	DATES OF ATTENDANCE	DISEASE OR CONDITION

Have you ever had the same or similar injury or sickness? ☐ Yes ☐ No

If 'Yes', (a) What was the diagnosis at the time?_____

(b) When did this occur? _____

(c) Please give names and addresses of doctors and hospitals by whom or in which you were attended, treated or examined.

For purposes of this claim, I became Disabled _____ and such Disability continued/has continued to _____ .

The first time I returned to work or place of business since becoming disabled was: Date_____	I returned to full time duties on: Date _____

For purposes of this claim, I became Partially Disabled_____and such Disability continued/has continued to_____ .

Of the occupational duties listed above, what duties were you not able to perform? Please describe why you were unable to perform these duties.

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PART B **INSURED'S STATEMENT FOR CONTINUANCE OF DISABILITY BENEFITS**

POLICY NO. _____

COMPANY	TYPE	YEAR OF ISSUE	MONTHLY BENEFIT	POLICY NUMBER	BENEFIT PERIOD

WORKER'S COMPENSATION

(a) Have you received a monetary Worker's Compensation award? ☐ Yes ☐ No

(b) If yes, when did payment begin? ____ / ____/_____

(c) What amount did/are you receiving? $ _____

(d) The award was/is payable:
☐ Weekly ☐ Biweekly ☐ Monthly

(e) Give date if payments have ceased _____ / ___ / _____

(f) Give name of worker's compensation carrier and claim number if known.

(g) Provide the documentation to support the information given above.

STATE CASH SICKNESS

(If you live in California, Hawaii, Puerto Rico, New Jersey, New York, Rhode Island)

(a) Are you receiving benefits? ☐ Yes ☐ No

(b) When did these benefits begin? ____ /____ / _____

(c) What amount are your receiving? $ _____

(d) Are you receiving these benefits
☐ Weekly
☐ Biweekly
☐ Monthly

(e) Provide the documentation to support the information given above.

SOCIAL SECURITY BENEFITS

(a) Have you applied for benefits?
☐ Yes ☐ No

(b) Have you been approved?
☐ Yes ☐ No

(c) Give total approved amount
$ _____

(d) If denied, have you appealed?
☐ Yes ☐ No

(e) Provide the documentation to support the information given above.

IMPORTANT – BE CERTAIN TO DATE AND SIGN THIS FORM AND HAVE YOUR TREATING PHYSICIAN COMPLETE THE ATTENDING PHYSICIAN'S STATEMENT PART C.

I understand that no insurance producer 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.

X Witness Name _____ X Date _____

Insured's Signature Witness Signature

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 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, Idaho, Indiana, Oklahoma: 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.

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.

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.

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PART C **ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (Front and Back)**

Name of Patient (Print)	Date of Birth	Policy Number

Present Address Street City State Zip Code

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for the completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers.

1. HISTORY

a. When did symptoms first appear or accident happen? Date:_____

b. Date patient ceased work because of disability? Date:_____

c. Is condition a result of complications of pregnancy? ☐ Yes ☐ No

d. Is condition a result of patient's employment? ☐ Yes ☐ No

e. Is condition due to a motor vehicle accident? ☐ Yes ☐ No

f. Has patient ever had a same or similar condition? (If yes, please describe) ☐ Yes ☐ No

g. Names and addresses of other treating physicians_____

h. Have you ever treated patient prior to this? (If yes, for what and when?) ☐ Yes ☐ No

i. Does patient have other disability coverage? (If yes, please identify) ☐ Yes ☐ No

ALL PARTS OF SECTION 2, 3, 5 AND 6 MUST BE COMPLETED TO CONSIDER THIS CLAIM

2. DIAGNOSIS

a. Diagnosis (including any complications) _____

b. Date of last examination _____

c. Subjective symptoms _____

d. Objective findings (include current X-rays, EKG's, laboratory data, and any clinical data) _____

3. DATES OF TREATMENT

a. Date of first visit **Date:** _____

b. Date of last visit **Date:** _____

c. Frequency ☐ **Weekly** ☐ **Monthly** ☐ **Other (specify):** _____

4. CARDIAC (If applicable)

a. Functional Capacity (American Heart Ass'n)

☐ **Class 1 (No Limitation)**

☐ **Class 2 (Slight Limitation)**

☐ **Class 3 (Marked Limitation)**

☐ **Class 4 (Complete Limitation)**

b. Blood Pressure (last visit) _____ / _____

Systolic **Diastolic**

5. NATURE OF TREATMENT (Surgery, medications, etc.)

6. EXTENT OF DISABILITY ***IMPORTANT***

a. Are you aware of the main duties the patient performs in his/her usual job/work/business: ☐ **Yes** ☐ **No**

b. Are you aware of the patient's background (education training, experience, etc.)? ☐ **Yes** ☐ **No**

c. Is patient DISABLED from performing HIS/HER JOB/WORK/BUSINESS? ☐ **Yes** ☐ **No**

If yes, give DATES of DISABILITY **FROM**_____ **TO** _____

d. If patient is able to perform some of the main duties of his/her job/work/business, please give...

DATES of PARTIAL DISABILITY **FROM**_____ **TO** _____

e. Based on your knowledge of the patient's background (see 6b.), is patient **DISABLED** from performing **ALL OTHER TYPES OF JOB/WORK/BUSINESS?**

☐ Yes ☐ No

f. If still **DISABLED**, when will patient be able to perform **HIS/HER JOB/ WORK/BUSINESS DUTIES?**

☐ 1-3 Months ☐ 3-6 Months ☐ 6-12 Months

☐ More than 12 months ☐ Indefinite

g. If still **DISABLED**, when will patient be able to perform **ANY OTHER JOB/ WORK/BUSINESS**? ***Base your opinion on your knowledge of patient's background (6b).

☐ 1-3 Months ☐ 3-6 Months ☐ 6-12 Months

☐ More than 12 months ☐ Indefinite

h. If **PARTIALLY DISABLED**, when will patient be able to resume full duties? Date: _____

i. Date patient was able to resume his/her normal work or business activities? Date: _____

7. Do you believe the patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

SECTIONS 8 THRU 12 MUST BE COMPLETED

CONTINUED ON NEXT PAGE

8. PROGRESS

a. Has patient... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

If recovered, date patient able to return to work? Date: _____

b. Has patient been hospital confined? ☐ Yes ☐ No Admitted_____ Discharged _____

Please give name and address of hospital

9. PHYSICAL IMPAIRMENT (*As defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)

☐ Class 2 – Medium manual activity* (15-30%)

☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35-55%)

☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity* (60-70%)

☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)

☐ Remarks:

10. MENTAL/NERVOUS IMPAIRMENT (if applicable)

☐ Class 1 – Patient able to function under stress and able to engage in interpersonal relations (No limitations)

☐ Class 2 – Patient able to function in most stress situations and engage in most interpersonal relations (Slight limitation)

☐ Class 3 – Patient able to engage in only limited stress situations and engage in limited interpersonal relations (Moderate limitation)

☐ Class 4 – Patient unable to engage in stress situations or engage in interpersonal relations (Marked limitation)

☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitation)

☐ Remarks:

11. REHABILITATION

a. Is patient a suitable candidate for rehabilitation? ☐ Yes ☐ No

b. If yes, please explain

12. REMARKS

X

PHYSICIAN'S SIGNATURE | PHYSICIAN'S NAME (PRINT) | DATE | DEGREE

NPI (National Provider Identifier) | *SOCIAL SECURITY OR TAX I.D. NUMBER

STREET ADDRESS | CITY OR TOWN | STATE OR PROVINCE | ZIP CODE | TELEPHONE

* Public Law 89-397 requires recipients of dividend, interest or other payments to furnish Social Security Numbers or Tax Identification Numbers to payors required to report such payment to the Internal Revenue Service. This Number must be furnished to the payor whether or not the payee is required to file a tax return, or is covered by Social Security.

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