



AIG Life Insurance Company

Wilmington, Delaware

American International Life Assurance Company of New York

New York, New York

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

New York, New York

Member companies of American International Group, Inc.

Administrative Office: 3600 Route 66, PO Box 1580, MSN 2-K, Neptune, NJ 07754-1580

CLAIMANT'S STATEMENT:

1. Complete, Sign and Date Your Portion of the Claim Form Including the Authorization for Release of Information and the Fraud Statement.
2. Have Your Physician Complete the Attending Physician's Statement.
3. Send All Documents to the Address Listed Above.

COMPLETE FOR ALL CLAIMS

Policy Number:		Name of Group:	
Name of Employee:			
Date of Birth:	Social Security Number:	Tax I.D. Number:	Telephone Number:
Address:		City:	State: Zip Code:

COMPLETE FOR DEPENDENT CLAIMS ONLY

Dependent's Name:		Relationship to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other	
Address:		City:	State: Zip Code:
Full Time Student <input type="checkbox"/> Yes If "Yes" and 18 Years or Older, Name of School: <input type="checkbox"/> No			
Address:		City:	State: Zip Code:

COMPLETE FOR ALL CLAIMS

Date of Injury:	Nature of Injury:
Briefly Describe How Injury Occurred: _____	

Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or correct Taxpayer ID number; and (2) that I am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) in this paragraph if you are subject to backup withholding and cross out item (3) in this paragraph if you are not a U.S. person (including a U.S. resident alien).

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE FURNISHING OF FORMS BY THE COMPANY DOES NOT CONSTITUTE AN ADMISSION THAT THERE IS ANY INSURANCE IN FORCE.

Claimant's Name (If other than the Insured):	
Claimant's Date of Birth:	Claimant's Taxpayer ID# (SSN or ETIN, whichever is applicable):
Employee's Name (Print):	
Signature of Employee, with Title, if any (U.S. person, including a U.S. resident alien):	Date:
Witness's Name (Print):	Witness's Signature: Date:



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POLICYHOLDER'S STATEMENT

This claim is being made for: Employee Spouse of Employee Dependent Child of Employee Other

Name of Claimant:

Address:	City:	State:	Zip Code:
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Claimant's Date of Birth:	Claimant's Social Security Number:
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Name of Employee:	Date of Birth:	Social Security Number:
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Employee's Address:	City:	State:	Zip Code:
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Group Policy Number:	Certificate Number:	Amount of Insurance:
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Name of Employer:	Telephone Number:
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Address of Employer:	City:	State:	Zip Code:
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Duration of Employment:	Employee's Job Title:	Weekly Earnings:	Insurance Class:
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<input type="checkbox"/> Union Employee <input type="checkbox"/> Full-Time <input type="checkbox"/> Non-Union Employee <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Part-Time	Average Number of Hours Worked Per Week:
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Last Full Day of Active Work:	Reason for Stopping Work: <input type="checkbox"/> Illness <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Retirement <input type="checkbox"/> Lay Off <input type="checkbox"/> Other (Explain):
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If Due to Illness, Disability Benefits Were Paid: From: To:	Carrier's Name:
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Carrier's Address:	City:	State:	Zip Code:
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If Contributory Insurance, to What Date Has Employee's Contributions Been Paid? From: To:

Send Check To:

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Name of Policyholder's Official Representative (Print):

Signature:	Date:
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COMPLETE FOR ALL CLAIMS: ATTACH COPIES OF MEDICAL RECORDS AND ALL OPERATIVE REPORTS FOR THE CLAIMED INJURY AND LOSS.

Name of patient: _____

Date of accident: _____ Date you last treated for this accident: _____

Is patient under care for any other illness or medical disorder? Yes No Unknown

If Yes, list diagnosis: _____

Did the underlying medical disorder contribute to the loss? Yes No Unknown

Are you the patient's regular physician? Yes No If No, physician's name: _____

Address: _____

Briefly describe accident: _____

Diagnosis and description of injuries: _____

Was patient hospitalized? Yes No If Yes, Admission Date: _____ Discharge Date: _____

Hospital Name: _____

Address: _____

COMPLETE FOR DISMEMBERMENT ONLY:

Loss: Right Arm Left Arm at Elbow Shoulder Hand Fingers, list digits: _____

Right Leg Left Leg Below Knee Above Knee Below Foot Above Foot Above Ankle Below Ankle

Date of amputation: _____

COMPLETE FOR DISMEMBERMENT AND/OR LOSS OF USE:

Function totally and irrecoverably lost? Yes No Hand Fingers Hemiplegia Paraplegic Quadriplegic

Other (coma, hearing, etc.) please describe: _____

COMPLETE FOR LOSS OF SIGHT/VISUAL IMPAIRMENT:

Visual Acuity at last observation Date: _____ Uncorrected Right Eye Left Eye

Date: _____ Corrected Right Eye Left Eye

Is loss entire and irrevocable? Right Eye Left Eye Yes No Date deemed entire and irrevocable: _____

COMPLETE FOR ALL CLAIMS

Were the injuries received in the accident on the date specified solely and independently the cause of loss? Yes No

Did the accident arise out of employment or occur while patient was working? Yes No

Did this injury cause any period of disability? Yes No Last date worked: _____ Return to work date: _____

If currently disabled, estimate return to work date: _____

Briefly describe the duties the patient is unable to perform: _____

List any other facts you feel will assist us in our review: _____

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name of Physician Completing This Form (Print)	Signature:	Date:
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Address:	City:	State:	Zip Code:
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Telephone Number:	Fax Number:
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Name of Physician Completing This Form (Print)	Signature:	Date:
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Address:	City:	State:	Zip Code:
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Telephone Number:	Fax Number:
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BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM, THE COMPANY SHALL NOT BE HELD TO ADMIT THE VALIDITY OF ANY CLAIM OR TO WAIVE THE BREACH OF ANY CONDITION OF THE POLICY.

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CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, American International Life Assurance Company of New York, 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; and communicable diseases including HIV or AIDS.

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

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General 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 AIG American General 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: AIG American General, P.O. Box 1580, Neptune, NJ 07754-1580. 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.

NAME OF CLAIMANT (PRINT)

SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE

DATE

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FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding 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 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.

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.

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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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.

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.

SIGNATURE OF INSURED _____

DATE _____