

Thank you for contacting us regarding your Accident Expense Policy. We understand your need to have your claim processed as soon as possible. To assist us in doing so, we will require the following:

1. Completed Accident and Health Insurance Claim form.
2. Completion of the HIPAA form (Authorization to Release Information). This document allows us to order records that may be required for the review of your claim.
3. Explanation of Benefit, (EOB), from your Primary Health Insurance Provider. This document allows us to review any provider discounts that may have been applied to your claim. Although your benefit is not offset by any provider payments, your benefits are adjusted for discounts or adjustments applied.
4. Copies of any medical information pertaining to your claim that will support the dates of visits, treatment, diagnosis and explanation of how the accident occurred. (e.g. ER Evaluation Notes, Operative Report, Doctor's Evaluation Notes)
5. Copies of all itemized bills supporting your claim. This will allow us to review your claim for all eligible benefits. Please do not send us the Account Summary, Receipts or Handwritten fees, quotes or estimates.

Our standard processing time for a claim is 15 days from receipt of all required documents. Your help in submitting the necessary requirements will allow us to process your claim within this time frame. Please note that if we do not receive the requirements within 30 days from the date of this letter, we will close the claim. However, any claim that is closed for lack of requirements can be reopened when those requirements are submitted.

We appreciate this opportunity to be of service to you. If you have any questions or need additional assistance, please contact our office at 1-800-811-2696.

Sincerely,
A&H Claims Department

American General

Life Companies

Accident and Health Insurance Claim Form

- American General Life Insurance Company, Houston, TX
 The United States Life Insurance Company in the City of New York, New York, NY

The Company shown above is solely responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

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. Have your attending physician complete Part B on reverse side.

STEP 3. 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 at P.O. Box 4277, Houston, TX 77210-4277.

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 or SPOUSE Claims Only

8. Name _____ 9. Date of Birth _____
10. Full time student Yes No If "Yes", submit proof of current enrollment. _____

III. Complete For ALL Claims

11. Describe condition: _____

12. Date symptoms first noticed: _____ 13. Date first consulted physician _____

IV. Complete For ACCIDENT Claims Only

14. Date of accident _____
15. Where did accident happen? _____
16. How did accident happen? _____

V. Date and Sign for ALL Claims

17. I certify that the above information is true and correct. A photographic copy of this certification shall be considered as effective and valid as the original.

Signature of Policyholder

Date

PART B TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Patient's Name _____

2. Diagnosis and concurrent conditions: (Provide ICD-9 Code.)

3. Report of Services

DATE OF SERVICE	PLACE OF SERVICE*	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	CPT CODE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*0—Doctor's Office
H—Patient's Home
IH —Inpatient Hospital
OH—Outpatient Hospital
NH—Nursing Home
OL—Other Locations

4. Date symptoms first appeared or accident happened. _____

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

6. Has patient ever had same or similar condition? Yes No If "Yes" when and describe. _____

7. Name of referring physician. _____

DATE SIGNATURE (Attending Physician) TELEPHONE

PHYSICIAN'S NAME (Please Print)

STREET ADDRESS CITY 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.

American General

Life Companies

HIPAA Authorization - Claims

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)