American General
Life Companies

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

New York, New York
Administrative Office: 3600 Route 66, P.O. Box 1581, MSN 2-E, Neptune, NJ 07754-1581
Phone: (800) 348-6908

1. Fully complete all pages of this claim form, including the HIPAA Authorization and Fraud Statement.
2. Attach fully itemized bills from your health care providers. An itemized bill contains: the patient's name; the date(s) services were rendered; a description of the services rendered; the CPT/Revenue code(s) for each service and the fee for each service; the diagnosis or ICD-9 code; and the name, address, telephone number, professional status and Federal Tax Identification number of the health care provider.
3. Attach the corresponding statements of payment or denial from all other insurance carriers, commonly known as an Explanation of Benefits.
4. Mail to the address listed above.

Name of Insured (first, middle initial, last) (Please Print)			Social Security Number	Policy Number E216,170	
Insured's Address, Street & No.			City	State	Zip
Phone No.	Date of Birth	Male ☐ Female ☐	Employed At	Occupation	
Single ☐ Divorced ☐ Other ☐ Married ☐ Widowed ☐	If Married, Spouse's Name			Spouse's Date of Birth	
Patient's Name for whom claim is being made (first, middle initial, last)			Patient's Relationship to Insured	Single ☐ Married ☐	
Patient's Address, Street & No.			City	State	Zip
Patient's Sex Male ☐ Female ☐	Patient's Date of Birth	If over age 19 and attending school or college, give name and address of school			
Nature of Sickness or Injury	Date first treated for this condition		Is condition related to employment? Yes ☐ No ☐ Is condition related to an auto accident? Yes ☐ No ☐		
If related to an injury, how, when and where did the injury occur?					
If hospitalized, give name and address of hospital			Dates of confinement		
Treating Physician's Name			Treating Physician's Telephone Number		
Treating Physician's Address, Street & No.			City	State	Zip

Please indicate by checking yes or no and providing the policy number if you and/or the patient have coverage under any of the following plans.

Medicare - Yes ☐ No ☐ Policy # _____ GHI - Yes ☐ No ☐ Policy # _____

Aetna - Yes ☐ No ☐ Policy # _____ United HealthCare - Yes ☐ No ☐ Policy # _____

BlueCross - Yes ☐ No ☐ Policy # _____ AARP - Yes ☐ No ☐ Policy # _____

Please list all other coverages you and/or the patient may have.

Policy # _____ Insurance Co. Name & Address _____

Policy # _____ Insurance Co. Name & Address _____

Policy # _____ Insurance Co. Name & Address _____

_____ _____

Signature of Insured Date

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HIPAA Authorization
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give 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, as well as other 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 American General Life Companies 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: The United States Life Insurance Company in the City of New York, P. O. Box 1581, MSN 2-E, Neptune, New Jersey 07754. 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)

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Fraud Statement

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.

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SIGNATURE OF INSURED **DATE**