AMERICAN GENERAL

Accelerated Life Benefit Request
Part A

AIG Life Insurance Company*

Wilmington, Delaware

A Member of American International Group, Inc.

Policy Benefits-Life/MSN-2K

Administrative Office: 3600 Route 66, P.O. Box 1580, Neptune, NJ 07754-1580 *This company does not solicit business in New York.

Please Fill out completely. Eligible employee completes and signs Part A. Employee's physician completes and signs Part B. If you have any questions regarding this application or your benefit amount, please contact GMD customer service dept. at 1-800-236-4537.

In order to qualify for this benefit, I understand that I must be terminally ill with a life expectancy of 12 months or less from the date of this request. This being the case, I hereby request an Accelerated Life Benefit payment in the amount of $_______________under the Group Life Insurance Policy, No. GL-____________________________ issued to ______________________________________.
(Policyholder/Employer)

Name of Insured: ____

Address: ____

Most Recent Hospitalization Date: Month________ Day________ Year________

Name and Address of Hospital: ____

____

Name and Address of Physician: ____

Describe, in your own words, your understanding of your health (condition): ________________________________

____

I hereby certify that the information provided above is true and correct to the best of my knowledge and belief.

Signature of Insured: ____

Date of Request: ____

Signature of Witness: ____

AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended me to furnish AIG Life Insurance Company or its representatives, any and all information, including medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records with respect to the terminal illness listed on this Accelerated Life Benefit Request form. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original. I understand and agree that the information to be disclosed will be used to determine eligibility for accelerated benefits under Group Life Insurance Policy No. GL- ______________________. I understand and agree that this authorization shall be valid for the duration of the claim. I understand that I or my authorized representative may ask for and receive a copy of this authorization.

Signature of Insured: ____

Any person who knowingly and/or with the intent to injure, defraud or deceive and insurance company or other person, files a statement of claim containing false, incomplete or misleading information, may be guilty of insurance fraud and subject to criminal and substantial civil penalties.

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Physician's Statement
Part B

AIG Life Insurance Company*

Wilmington, Delaware
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The patient is requesting an advance life insurance benefit. Your statement is required to determine the patient's eligibility.

1. a. When did symptoms first appear or accident happen: Month________ Day________ Year________
   b. Date the patient was informed of diagnosis: Month________ Day________ Year________
   c. Has patient ever had the same or similar condition? ☐Yes ☐ No
   If yes, Month________ Day________ Year________
2. a. Is patient's condition terminal? ☐Yes ☐ No
   b. If Yes, is life expectancy 12 months or less? ☐Yes ☐ No
   c. Diagnosis (including and complications):
   ____
   ____
   d. Subjective symptoms: ______________________________
   ____
   ____
   e. Objective findings (including current X-rays, EKGs, Laboratory Data and Clinical findings):
   ____
   ____
   f. If your opinion, has this condition affected the mental capacity of the patient? ☐Yes ☐ No
   g. Other comments: ______________________________
   ____
   ____
3. Dates of Treatment:
   First Visit Month________ Day________ Year________
   Last Visit Month________ Day________ Year________
   Frequency ______________________________
4. Nature of Treatment (including surgery and medications prescribed, if any): ______________________________
   ____
   ____
5. Has patient ☐ recovered? ☐ improved? ☐ remained unchanged? ☐ retrogressed?
   Is patient ☐ ambulatory? ☐ house confined? ☐ bed confined? ☐ hospital confined?
   Has patient ever been hospital confined? ☐Yes ☐ No If Yes, Month________ Day________ Year________

____
Print Physician's Name | Degree | Specialty | Telephone No.

____
Street Address | City | State or Province | Zip Code

I hereby certify that to the best of knowledge, information, and belief, the information provided herewith is true and correct.

____
Signature of Attending Physician

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ADDENDUM

1. The following statement is applicable to California claimants:

   For any 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.

2. The following statement is applicable to New Jersey claimants:

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

3. The following statement is applicable to Pennsylvania claimants:

   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 and subjects such person to criminal and civil penalties.

4. The following statement is applicable to Florida claimants:

   Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

5. The following statement is applicable to Colorado claimants:

   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 policy holder 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.