

THE UNITED STATES LIFE Insurance Company
An American General Company

EMPLOYER'S STATEMENT/TOTAL DISABILITY BENEFITS

AS REQUIRED BY LAW, 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.

This statement must be completed by the Employer, or his duly authorized agent, as a Superintendent, Paymaster, etc. It must not be completed by a Clerk, Bookkeeper or Foreman, unless specially authorized, nor by any Agent of The United States Life Insurance Company.

1. Full name of Insured _____ Group Policy Number _____ Certificate Number _____

2. Name and business address of Insured's employer. (Please include telephone number.) _____

3. Nature of business. _____

4. What was exact nature of work performed by Insured prior to his present condition? _____

5. Insured's job title _____ Insurance Classification _____ Average number of hours worked per week _____

6. When did Insured enter your employ? _____

7. (a) When was Insured compelled to give up part of his duties? (Give exact date.) _____

7. (b) When was Insured compelled to give up all his duties? (Give date last worked.) _____

8. Is Insured's illness or injury the sole cause of his absence from duty? If not, give particulars. _____

9. Has Insured been absent from work before because of any illness or injury? If so, give particulars. _____

10. Date premium payments terminated on Insured's coverage. If not yet terminated, give date of expected termination. _____

11. Amount of insurance. (This should be the amount of coverage as of the last day worked.) _____

Signature _____

Witness _____

Official Position _____

Dated _____
MONTH DAY YEAR

Dated _____
MONTH DAY YEAR

Disability
Claim No. _____

Pol. No. _____ Date _____

Name _____

Address _____

STATEMENT NO. 3A _____

By _____

Address _____

Received _____

NOTICE

In furnishing this blank the Company does not thereby admit that there is any policy in force in the Company covering the person claiming to be disabled; and the Company expressly reserves all its rights and defenses.

There is no need to employ any person to help collect any sum rightly due under the insurance policies of The United States Life Insurance Company, nor need any one incur any expense for this purpose except to pay the customary charges or fees required to complete the several forms or statements to be furnished.

STATEMENT No. 3A: Employer's Statement: To be made by Claimant's Employer. If the Claimant is employed by an association, company, corporation, etc., this statement should be made by an officer of such concern; preferably by the officer under whom the Claimant was employed.

Please answer every question distinctly and fully and write below any additional information or details which you think are pertinent.

ADDITIONAL INFORMATION OR DETAILS