Proof of Death Claimant's Statement

☐ **American General Life Insurance Company,** P.O. Box 305800, Nashville, TN 37230-5800
☐ **The United States Life Insurance Company in the City of NY**
A member of American International Group, Inc. (AIG)
Overnight: ATTN: Life Claims, #2, American General Center, Nashville TN 37250-0002

To Be Completed By Each Beneficiary *(please print)*					Claim Number
POLICY NUMBER/GROUP NUMBER & CERTIFICATE NUMBER (If multiple policies, please list all)					
DECEASED FULL NAME (include middle name)			DECEASED SOCIAL SECURITY NUMBER		DATE OF BIRTH
CAUSE OF DEATH	DATE OF DEATH	List other hyphenations, nicknames, aliases and/or maiden names used by deceased in the past.			
CLAIMANT'S NAME			DATE OF BIRTH		SOCIAL SECURITY # OR TIN
ADDRESS	CITY		STATE	ZIP	RELATIONSHIP TO DECEASED
EMAIL ADDRESS			TELEPHONE NO. ( )		ALT NO. ( )

Have you assigned any of the proceeds of this policy to a Funeral Home? ☐ Yes ☐ No If yes, who have the proceeds been assigned to? ______
(If assigned, we must have the assignment papers to process the claim, please provide a copy of the Funeral Home assignment.)

LIST EACH ASSIGNEE WITH CONTACT NUMBER

I have read and I understand the important Fraud Disclosure information located on page 8 of this form. 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.

AUTHORIZATION REGARDING ______ ("Insured")
I, the Claimant / Legal Representative of the Insured authorize each insurance company listed above and American General Life Companies LLC (an affiliate services company) (collectively, the "Company") and their authorized representatives including their employees and agents, to provide information to, and, to receive information from, MIB Inc., which operates an information exchange that assists insurance companies with benefit administration, claims, and fraud prevention and detection activities. The authorization will be valid for the duration of the claim or 24 months, whichever is longer. I understand that I may revoke it by giving written notice to the Company, but any action taken by the Company before receipt of such notice will be valid. I acknowledge that I am entitled to obtain a copy of the authorization and a copy will be as valid as the original.

PLEASE SIGN HERE
Signature of Claimant/Legal Representative of the Insured — Printed Name — Date

Certification of Trustee(s) complete this section only if Beneficiary is the Trust

Name of Trust: ______
Tax ID of Trust: ______

The undersigned hereby certify as follows:
1. That they are Trustees under a Trust Agreement dated: ______ Amended: ______
2. That they are the Trustees designated as beneficiary under the above numbered policy(ies);
3. That said Trust Agreement is in full force and effect and that by its terms they are empowered to receive payment of the proceeds of the above policy(ies);
4. That, if applicable, said Trust/Plan is presently fully qualified having met the requirements of Section 401(a) of the Internal Revenue Code.

It is understood and agreed by the undersigned that payment of such proceeds to the Trustees shall discharge the Company from any and all liability therefore and that the Company shall have no responsibility for the carrying out of the Trust Agreement.
The plural as used herein shall include the singular wherever applicable.

Signed this ______ day of ______ 20 ______.

Individual Trustee(s): (Trustee Signature) (Printed Name)

(Signature) (Printed Name) (Signature) (Printed Name)

OR

Corporate Trustee: ______ (Name of Corporate Trustee)

By: (Officer's Signature) (Printed Name) (Title)

(All co-trustees must sign.)

AGLC180A Rev0419

------- Payment of Policy Proceeds -------

If your insurance benefit is $50,000 or more, you may elect to have the proceeds paid through a free, interest-bearing account called the Instant Access Account. (This option is not available for residents of Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York.)

- This is a draft account whereby you may draw down the insurance proceeds and interest by drafting drafts which are payable through The Bank of New York Mellon.
- A personal draft book will be mailed to you once your claim has been approved. You may access your account by writing a draft for $250.00 or more. If you wish, you can write a single draft for the entire amount, including interest, to close your account. Your drafts are payable through The Bank of New York Mellon. The delivery of your draft book constitutes payment of your full benefit amount.
- There are no monthly service charges, per-draft charges or draft fees. Fees will be charged for the following special services: any draft presented for payment against insufficient funds, any stop payment order, and any draft or statement copies. The charging bank reserves the right to change its fees at any time.
- Should your Instant Access Account balance drop below $10,000, the account will be automatically closed and a draft for the balance mailed to you, with accrued interest on the 10th day of the following month.
- You will receive a Quarterly statement, showing all transactions, interest credited and the applicable rate(s) of interest for the period.
- Your Instant Access Account earns interest at a periodic interest rate determined by the company which is set after monitoring current short term rates and other prevailing rates available in the marketplace.
- The interest rate is subject to periodic review and may be adjusted by the company. There is not a minimum interest rate credited to the account.
- Interest is compounded daily and credited to your account monthly. Interest may be taxable; please consult with your tax advisor regarding taxable interest amounts.
- To obtain the current interest rate for your account, please review your Quarterly statement or call 1-888-562-9158 (M-F) 8:00AM to 7:00PM Eastern Time.
- Both your principal and any interest you earn are guaranteed by American General Life Insurance Company (American General Life).
- The Instant Access Account is not insured by the Federal Deposit Insurance Corporation (FDIC). Its funds are guaranteed by the State Guaranty Associations. Please contact the National Organization of Life and Health Insurance Guaranty Associations (www.nolhga.com) to learn more about coverage of your account.
- Account balances are the liability of American General Life, and American General Life reserves the right to reduce account balances for any payment made in error.
- Settlement options under any policy for which benefits are paid under a Instant Access Account are preserved until the entire Instant Access Account is withdrawn or the balance drops below $10,000.00.
- If an initial life insurance benefit is less than $50,000, American General Life will send you a check for the total benefit amount.
- Any value remaining in your Instant Access Account may be transferred to the appropriate state authority as unclaimed property if no activity occurs in the account within the time period specified by applicable state law.

If you have questions regarding the Instant Access Account, please call 1-888-562-9158 (M-F) 8AM to 7:00PM Eastern Time or write to Instant Access Account, P.O. Box 534025, Pittsburgh PA 15253-4025.

Select one of the following choices:

- ☐ Proceeds left on deposit - the death benefit is left on deposit with us earning interest at a rate we determine. The funds are accessible through an Instant Access Account, as described above.
- ☐ Lump sum payment - the death benefit is paid in a single lump sum settlement check.
- ☐ Payments for a specific period - you will receive equal monthly payments for a specific period you select. The number of payments you wish to receive is: ________ (in months)
- ☐ Payments for a specific amount - you will receive equal monthly payments of an amount you selected until the death benefit, and any accrued interest, is paid in full. The amount of each payment you wish to receive is: $________________ .
- ☐ Payments for life - you will receive equal monthly payments for your life. Upon your death, payments will cease.
- ☐ Payments for life with a guaranteed period - you will receive equal monthly payments for at least the guaranteed period and payments will continue beyond that period until your death.*

*Any amount remaining upon your death would be paid according to the beneficiary designation established for the payments.

If you do not select one of the options above for payment, any proceeds payable will be paid by company check.
Note: The signature on this Claimant's Statement will be used as your signature card for the Instant Access Account, if selected.

Signature ______________________ Date: ______________________

Federal & State Withholding (must be completed):

Income Tax Withholding: The distribution(s) you receive from the Insurer may be subject to federal income tax withholding unless you are eligible to elect out of withholding and elect not to have withholding apply. (However, we must have your correct US Taxpayer Identification Number (TIN) on page 2 in order for you to elect into or out of withholding.) Withholding will only apply to the taxable portion of your distribution. Your withholding election will remain in effect until you revoke it. Unless you elect otherwise above, we will withhold 10% of the taxable amount of your distribution.

States with a state income tax either require mandatory withholding or allow voluntary withholding. If your state requires mandatory withholding, we will withhold the mandatory amount without regard to your election above. Should you elect state income tax withholding and fail to provide a specific dollar or percentage amount and your state of domicile does not provide a default state withholding amount, we will withhold for state income tax purposes 5% of the taxable portion of your distribution for state income tax. Should your state of domicile require a specific state withholding form, your state income tax withholding election will not be taken into account (and we will withhold based on the state mandatory withholding rate or our default state income tax withholding) until the required form is received at our Customer Service Center.

Withholding Election: If you are eligible to elect out of and elect not to have federal or state income tax withheld, please be advised that you may be liable to pay the federal or state income tax on your distribution as deemed appropriate by the Internal Revenue Service or state taxing authority, regardless of your election. You may also be subject to tax penalties if your payments of estimated tax and withholding, if any, are not adequate.

Notice to non-resident aliens and for payments made outside the U.S.: A payment to a non-resident of the US or made to an address outside the United States may be subject to federal income tax withholding at a rate of 30% of the taxable portion of the distribution. The payee may submit a completed IRS Form W-8BEN (or if applicable, a Form W-8BEN-E) and elect reduced withholding if the payment is eligible for reduced withholding.

Federal Withholding Election	**State Withholding Election**
☐ **DO NOT** withhold any federal income taxes unless mandated by law. ☐ **DO** withhold federal income taxes in the amount of $________ or _____ % (cannot be less than any mandatory withholding).	☐ **DO NOT** withhold any state income taxes unless mandated by law. ☐ **DO** withhold state income taxes in the amount of $________ or _____ % (cannot be less than any mandatory withholding).

The Company will provide you and the Internal Revenue Service with an informational tax form after the close of the calendar year.

OWNER'S TAX CERTIFICATION (Substitute Form W-9) - To be completed only by U.S. persons (including U.S. citizens and resident aliens). If not a U.S. person, you are required to submit the applicable IRS Form W-8 series (BEN, BEN-E, ECI, EXP or IMY).

Under penalties of perjury, I certify that the taxpayer identification number listed on this form is my correct SSN and I am a U.S. Citizen or other U.S. person (including resident aliens). I further certify that I am exempt from backup withholding and/or the Foreign Account Tax Compliance Act ("FATCA") reporting unless I check the applicable box(es) below:

☐ I have been notified by the Internal Revenue Service that I am subject to backup withholding due to the failure to report all interest or dividends. The Company is required to withhold income tax on any payments, which include interest and dividends when the owner is subject to backup withholding.

☐ I am subject to the reporting requirements of the FATCA.

Please consult your tax advisor with any questions you may have regarding this certification.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Claimant / Beneficiary Signature

Date ____________________

If You Are Claiming Any Accidental Death Benefits

Please complete this section: (Include copies of available newspaper clippings and/or police report giving circumstances)
Type of Accident:

____

Date: ______________ Location: ______________

Details: ______________________________

____

____

____

Investigating Officer/Agency:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

If Manner Of Death Was Homicide

Motive? ______________________________ Arrest Made? ☐ Yes ☐ No

Suspects? (Give names) ______________________________

Trial pending? ☐ Yes ☐ No

Witnesses? (Give names, addresses, phone numbers)

____

Investigating Officer/Agency:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

If Policy Has Been In Force For Less Than Two Years, please complete this section:

Please provide a statement of medical history for the deceased. Include Name, Address, Phone Number and year of treatment for all Doctors, Hospitals, and Clinics that had treated the deceased in the last 10 years. Also, include the name of the Pharmacy and Group Insurance Carrier. If additional space is needed please include a separate page if necessary.

The Company Will Order These Records.

Health or Member ID No.: ______________	Insured: ______________
Carrier: ______________	Pharmacy: ______________
Address: ______________ ______________	Address: ______________ ______________
Phone Number: ______________	Phone Number: ______________
Doctor/Hospital: ______________ Address: ______________ ______________ ______________ Phone Number: ______________ Year of Treatment: ______________	Doctor/Hospital: ______________ Address: ______________ ______________ ______________ Phone Number: ______________ Year of Treatment: ______________
Doctor/Hospital: ______________ Address: ______________ ______________ ______________ Phone Number: ______________ Year of Treatment: ______________ Year of Treatment: ______________	Doctor/Hospital: ______________ Address: ______________ ______________ ______________ Phone Number: ______________ Year of Treatment: ______________ Year of Treatment: ______________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") Authorization to Obtain and Disclose Information

A member of American International Group, Inc. (AIG)

____ ___/___/___

Name of Insured (Please Print) **Date of Birth**

I, the Insured above or the Personal Representative acting on behalf of the Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated services company (AGL, US Life and affiliated services companies 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 the Insured's health (except psychotherapy notes) and the Insured's 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 to:

- any physician, nurse or medical practitioner or practitioner group;
- 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 of the Companies (as defined above) which may have provided the Insured with life, accident, health, and/or disability insurance coverage, or to which the Insured may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- the Insured's employer, group policy holder, or benefit plan administrator;
- the Medical Information Bureau (MIB); and
- ____

I understand that the information obtained will be used by the Recipient to:

- determine the Insured's eligibility for benefits under and/or the contestability of an insurance policy; and
- detect 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 Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the 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 Insurance Company, Attn: Life Claims Department, P.O. Box 305800, Nashville, TN 37230-5800. I understand that my revocation of this authorization will not affect uses and disclosure of the Insured's health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under the Insured's 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 information necessary to consider a claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under the Insured's 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, upon request, a copy of this authorization.

Printed Name of Insured or Personal Representative

Policy Number/ Control Number

X

Signature of Insured or Insured's Personal Representative

Date

Printed Name of Witness

Relationship

X

Witness Signature (if required)

Date

Description of Authority of Personal Representative

AIG

Proof of Death

American General Life Insurance Company
The United States Life Insurance Company in the City of New York
A member of American International Group, Inc. (AIG)
Service Center: P.O. Box 305800, Nashville, TN 37230-5800

Claim #

USE THIS FORM ONLY WITH CLAIMS FOR NATURAL DEATH BENEFITS
OF $15,000.00 OR LESS ON INCONTESTABLE POLICIES

To be completed by licensed practicing Physician, Coroner, or Funeral Director

X

I certify that ______________________, Social Security Number ______________, the Insured/Beneficiary named in policy __________ died on ______________, ______. The date of birth is ______________, ______. This person died at ______________________. The principal cause of death was ____

Date ______________________

X ______________________
Physician-Coroner-Funeral Director
(Strike out titles not applicable)

____
Print Name

X ______________________
Witness Signature

____
Print Witness Name

____
Address

____
City State Zip Code

X

Phone # ______________________

Phone # ______________________

Additional policies: