Instructions For Filing A Claim

American General Life Insurance Company
A member of American International Group, Inc. (AIG)

Your Cancer Care policy is a limited benefit plan that is designed to supplement the cost of medical procedures and expenses due to the treatment of Cancer. There are three plan options available.

Cancer Care Gold provides coverage for a First Occurrence (Internal Cancer only); Hospital Confinement; Ambulance; Physician visits (while confined); Nursing services (rendered in hospital); Skin Cancer surgery; Anesthesia; Nursing services under home health care plan; Skilled nursing facility confinement; Hospice care; Radiation, Chemotherapy; Blood, Plasma; Specified disease screening test; Prosthesis; Waiver of premium. Refer to your policy for details.

Cancer Care Platinum provides coverage for the above plus, Intensive care unit; Transportation to a non-local hospital; Second surgical opinion; Bone marrow transplant; Anti-nausea prescriptions; Disability Income; Lodging benefit. Refer to your policy fro details.

Cancer Care Platinum Plus provides coverage for the benefits listed above plus, Ambulatory surgical center; Stem cell transplant; Experimental treatment; National Cancer Institute evaluation. Refer to your policy for details.

To file a claim:

- Print and complete the Accident & Health Insurance Claim forms
- Complete the HIPAA form.
- Submit a copy of the Pathology Report with your initial diagnosis.
- Submit the itemized bills showing the Diagnosis (ICD-9) and Procedure (CPT) codes.
- Submit the Disability Claim packet for Premium Waiver benefits.

If your claim is within the policy's contestability period, we may request additional information.

Our standard time for reviewing a claim is 15 days from receipt of all the required documents. Your help in submitting all the necessary requirements will allow us to process your claim within this time frame.

If you have any questions or need additional assistance, please contact our Claim office at 800-811-2696.

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
A member of American International Group, Inc. (AIG)
Service Center: P.O. Box 1500, Nashville, TN 37202-1500

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.
STEP 3. When you and your attending physician have completed the form, in detail, attach the requested requirements and forward to us for review and processing to P.O. Box 1500, Nashville, TN 37202-1500 or fax to: 615-749-2932.

PART A TO BE COMPLETED BY INSURED
Please Note: Failure to complete this form IN FULL may delay the review of your claim.

1. Policyholder Name _____ 2. Policy Number(s)_____
3. Date of Birth _____ 4. Home Phone_____
5. Home Address _____ 6. Office Phone_____

_____

Complete for Spouse/Dependent

7. Name _____ 8. Date of Birth _____
9. Full time student ☐ Yes ☐ No If "Yes"and 18 years or older submit proof of current school enrollment.

Complete for an Illness/Sickness Claim

Claim for Cancer: Submit the Pathology Report and Itemized bills
Claim for Hospital Confinement: Submit the Itemized Hospital bill
Claim for Critical Illness: Submit the medical records Re: Initial Diagnosis
10. Describe condition: _____

_____

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

Complete for an Accident Claim

Requirements: The initial medical evaluation notes from emergency room, urgent care center or physician. The itemized bills and copies of the Explanation of Benefits from your major medical plan or other insurance coinciding with the bills you are submitting.
13. Date of accident _____
14. Where did accident happen? _____
15. How did accident happen? _____

_____

16. Is the insured/dependent covered under any other group health insurance or service plan or federal medicare/medicaid program? ☐ Yes ☐ No

Date and Sign

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.

Policyholder Signature

X

Policyholder signed on (date) _____

PART B TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Patient's Name _____ Date of Birth _____
2. Diagnosis and concurrent conditions: (Provide ICD-10 Codes.)

   _____

   _____
3. Report of Services

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

*0—Doctor's Office IH —Inpatient Hospital NH—Nursing Home
H—Patient's Home OH—Outpatient Hospital 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? ☐ No ☐ Yes If "Yes" when and describe. _____

   _____
7. Name of referring physician. _____
8. Is patient covered under any Health Insurance / Service plan / Government Program? ☐ No ☐ Yes
   Name of Carrier: _____
9. Was patient hospital confined? ☐ No ☐ Yes Name of Hospital_____

   Provider Tax ID Number:_____

   Address _____

   This will confirm that the patient _____(is/was) a patient in

   this hospital and is charged room and board for _____days from_____to _____.

   Title: _____Date _____

   Signature: _____

Attending Physician Signature

X

Attending Physician signed on (date) _____

Physician's Name (please print) _____

Telephone_____

Address _____

_____

>>> Please detach & keep page <<<

FRAUD WARNING DISCLOSURE

In some states we are required to advise you of the following: Any person who knowingly intends to defraud or facilitates a fraud against an insurer by submitting an application or filing a false claim, or makes an incomplete or deceptive statement of material fact, may be guilty of insurance fraud.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 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.

Delaware, Idaho, Indiana, Oklahoma: WARNING - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

Maine, Tennessee, Virginia, Washington: WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject 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.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances be present, it may be reduced to a minimum of two (2) years.

AIG

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 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

Statement of Medical History

American General Life Insurance Company (AGL)
The United States Life Insurance Company in the City of New York (USL)
A member of American International Group, Inc. (AIG)

Service Center: P.O. Box 305800 • Nashville, TN 37230-5800

Please furnish a statement of medical history for the insured. Include the Name, Address, Phone Number and Year of treatment for all Doctors, including family doctor, Hospitals, Clinics that had ever treated the insured. Also, include the name of the Pharmacy and Group Insurance provider/carrier.

THESE RECORDS WILL BE ORDERED

Policy No.: _____ Insured: _____

Health Insurance Provider/Group Carrier: _____ Pharmacy: _____

Group #: _____

Phone #: _____ Phone #: _____

Family Doctor: _____ Pharmacy: _____

Phone #: _____ Phone #: _____

Year of Treatment: _____

Doctor/Hospital: _____ Doctor/Hospital: _____

Phone #: _____ Phone #: _____

Year of Treatment: _____ Year of Treatment: _____

Doctor/Hospital: _____ Doctor/Hospital: _____

Phone #: _____ Phone #: _____

Year of Treatment: _____ Year of Treatment: _____

Doctor/Hospital: _____ Doctor/Hospital: _____

Phone #: _____ Phone #: _____

Year of Treatment: _____ Year of Treatment: _____