American General Life Insurance Company
A member of American International Group, Inc. (AIG)
P O Box 305800
Nashville TN 37230-5800

Proof of Death Claimant's Statement

To Be Completed By Each Beneficiary ***(please print)***			Claim Number
POLICY NUMBER	POLICY NUMBER	POLICY NUMBER	POLICY NUMBER
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
ALTERNATE ADDRESS (Only complete if mailing to separate address from above)	CITY	STATE	ZIP	IN CARE OF
EMAIL ADDRESS		TELEPHONE NO. ( )		ALT NO. ( )

Have you given the Funeral Home an Assignment to collect any amount due under this claim? ☐ Yes ☐ No If yes, what amount? $ _____ (Attach copy of assignment)

FUNERAL HOME NAME	FUNERAL HOME TELEPHONE NO. ( )

IRS/DOL Guidance re: Marriage
For Federal tax law and ERISA purposes, under current IRS and DOL guidance (1) a same-sex marriage that was valid in the state or country it was entered into will be recognized by the IRS and /or DOL, regardless of the married couple's place of domicile; and (2) although a state may recognize domestic partnerships or civil unions, the terms "spouse," "husband and wife," "husband" and "wife" do not include individuals who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

I have read and I understand the important Fraud Disclosure information located on page 6 of this form.

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.)

------- 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 Convenience Benefit 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 State Street Bank and Trust Company.
- 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 State Street Bank and Trust Company. 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 Convenience Benefit 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 monthly statement, showing all transactions, interest credited and the applicable rate(s) of interest for the period.
- Your Convenience Benefit 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 monthly statement or call 1-800-888-2402 (M-F) 7:00AM to 6:00PM Central Time.
- Both your principal and any interest you earn are guaranteed by American General Life Insurance Company (American General Life).
- The Convenience Benefit 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 Convenience Benefit Account are preserved until the entire Convenience Benefit 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 Convenience Benefit 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 Convenience Benefit Account, please call 1-800-888-2402 (M-F) 7:00AM to 6:00PM Central Time or write to American General Life Insurance Company, P.O. Box 305800, Nashville, TN 37230-5800.

Select one of the following choices:

☐ Please pay the insurance proceeds through the Convenience Benefit Account **(Not available if you are a resident of Alaska, Arkansas, Connecticut, Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Rhode Island and New York)**.

☐ Please pay the insurance proceeds by Lump Sum - Settlement Check.

☐ Please pay the insurance proceeds by means of a Settlement Option permitted by the Policy (please refer to settlement options in the policy and indicate your preference).

_____

_____

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 Convenience Benefit Account, if selected.

Signature: _____

Date: _____

WITHHOLDING ELECTION:

Please read the Notice of Federal Withholding Election on the bottom of this page prior to completing this section.

I hereby accept full and sole responsibility for payment of federal and state taxes which may be associated with this claim.

Unless you check Option "A" below, "I DO NOT want to have Federal income tax withheld," we are required to withhold at least 10% of the taxable amount.

_____ A. I DO NOT want to have Federal income tax withheld.

_____ B. I DO want to have _____ % Federal income tax withheld (10% minimum).*

Even if you elect not to have Federal income tax withheld, you are liable for payment of Federal income tax on the taxable portion of the distribution. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

* Note: If you elect federal withholding, state income tax withholding is mandatory in the following states: CA, DE, GA, IA, KS, ME, MA, MS, NC, OK, OR, VT, and VA. Unless these states' laws require otherwise, or you request a different withholding amount by providing American General Life Insurance Company the applicable state form, we will withhold state income tax based on federal guidelines. In other states with a state income tax, state income tax withholding is voluntary. However, you may be liable for payment of state income tax on the taxable portion of your distribution.

TAXPAYER IDENTIFICATION NUMBER:

This section must be completed and signed by the Claimant / Beneficiary identified on Page 1 of this form. Failure to do so may delay your request.

Please enter your taxpayer identification number in the appropriate box. For individuals and sole proprietors, this is your social security number. For other entities, it is your employer identification number. If you do not have a number, see IRS Publication 505.

Social Security Number

			–			–				

OR

Taxpayer Identification Number

		–							

CERTIFICATION: Under penalties of perjury, I certify that: 1. the number shown on this form is my correct taxpayer identification number (or I am waiting for the number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I certify that I am a U.S. Person (as defined in the instructions to IRS Form W-9).

_____ _____

Claimant / Beneficiary Signature Date

NOTICE OF FEDERAL WITHHOLDING ELECTION

The distributions you receive from American General Life Insurance Company are subject to Federal income tax withholding unless you elect not to have withholding apply. Withholding will only apply to the portion of your distribution that is included in your income subject to Federal income tax. Thus, for example, there will be no withholding on the return of your nondeductible contributions to the contract.

You may elect not to have withholding apply to your distribution by marking Option A under the Withholding Election section on Page 2 of this form. If you do not mark Option A, Federal income tax will be withheld from the taxable portion of your distribution.

If you elect not to have withholding apply to your distribution or if you do not have enough Federal income tax withheld from your distribution, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.

HIPAA Authorization - Life Claims

Authorization to Obtain and Disclose Information

_____ _____/_____/_____

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

I, the Insured above or the personal representative of such Insured if deceased or under a legal disability, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company and its affiliates (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.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- 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 other AIG member company 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 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 company listed above is subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the 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: American General Life Insurance Company, Attn: Life Claims Department - 380S, 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 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 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 | Control Number/Policy Number

_____ _____

Signature of Insured or Insured's Personal Representative | Date

_____ _____

Printed Name of Witness | Relationship

_____ _____

Witness Signature (if required) | Date

_____

Description of Authority of Personal Representative

Complete and return with your claim.

American General Life and Accident Insurance Company
A member company of American International Group, Inc.

AIG AMERICAN GENERAL

PROOF OF DEATH

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

To be completed by licensed practicing physician, coroner or funeral director

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 _____

_____
PHYSICIAN-CORONER FUNERAL DIRECTOR (Strike out titles not applicable)

Print Name: _____

Witness _____

_____
Address

Print Witness Name_____

_____
City State Zip Code

Phone #_____

Phone # _____