American General
Life Companies

Disability Income Claims-
Continuation

American General Life Insurance Company
American International Companies
☐ American General Life Insurance Company of Delaware
☐ Delaware American Life Insurance Company
Pacific Union Assurance Companies
P.O. Box 4443, Houston, TX 77210-4443

ATTENDING PHYSICIAN'S STATEMENT ON PAGE 2 SHOULD BE COMPLETED

STATEMENT OF INSURED

Name of Insured _____ Policy Number _____

Cause of disability _____

Have you received medical treatment since your first report? ☐ Yes ☐ No

If "Yes", give names of Doctors. _____

Date of last treatment. _____

Have you been hospitalized or undergone surgery since your last report? ☐ Yes ☐ No

If "Yes", give name of hospital _____

_____

Date of admission _____ Date of discharge _____

Type of surgery _____

TOTAL DISABILITY–Are you now unable to work? ☐ Yes ☐ No

If "Yes", when do you expect to return to work? _____

If "No", give exact date you returned to work. _____

PARTIAL DISABILITY–Are you able to do part of your work? ☐ Yes ☐ No

If "Yes", can you do MORE than 50% of your work ☐ 50% or LESS of your work? ☐

Exact date partial disability began. _____ Exact date partial disability ended (if it has). _____

During this period, what important duties were you unable to perform? _____

When do you expect to resume all your regular work? _____

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.

These statements are full, complete and true. I authorize any physician, clinic, hospital, employer or other organization to furnish American General Life Insurance Company any information regarding my history, treatment or employment. A photographic copy of this authorization shall be as valid and effective as the original.

Date _____ Signature of Insured _____

Address of Insured _____
Street City State Zip Code

STATEMENT OF EMPLOYER

Employee returned to work .....Part Time _____ Full Time _____
Date Date

Was illness or injury covered under Workmen's Compensation? ☐ Yes ☐ No

If "Yes", give name and address of compensation center.

Name _____

Address _____
Street City State Zip Code

Date _____ Signature _____ Title _____

HEALTH INSURANCE CLAIM – Individual – Disability Income

PART A - TO BE COMPLETED BY PATIENT (INSURED)

Patient's Name _____

Address _____

Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

_____

Signed (Patient, or Parent if Minor)

PART B - ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS _____
   (IF DIAGNOSIS CODE OTHER THAN ICDS* USED, GIVE NAME): _____
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT ☐ YES ☐ NO
   PREGNANCY? ☐ YES ☐ NO IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. _____
3. DATES OF SERVICES _____
   (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT)
4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED _____
5 DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION _____
6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO
   IF "YES" WHEN AND DESCRIBE: _____
7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED? (UNABLE TO WORK).
   FROM _____ THRU _____
9 PATIENT WAS PARTIALLY DISABLED. FROM _____ THRU_____
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK _____
11. PATIENT WAS HOUSE CONFINED _____
12. DOES PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO
    IF "YES" PLEASE IDENTIFY _____

_____

DATE PHYSICIAN'S NAME (PRINT)

_____

SIGNATURE DEGREE

_____

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE

_____

TELEPHONE

*ICDA – International Classification of Diseases

Mail Completed Form to: CLAIMS DEPARTMENT
AMERICAN GENERAL LIFE INSURANCE COMPANY
PO BOX 4373
HOUSTON, TX 77210-4373