American General
Life Companies

Employer's Statement
Total Disability Benefits

American General Life Insurance Company (AGL)
Service Center: P.O. Box 4443 • Houston, TX 77210-4443

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.

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 specifically authorized by a duly authorized officer or employee of AGL.

1. Full name of Insured _____
2. Name and business address of Insured's employer: _____

   _____
3. Nature of business: _____

   _____

   _____
4. Occupation at time of disability: _____

   Percentage of time: Supervising _____ Driving _____ Sitting _____ Lifting _____ (Average weight lifted _____)

   FOR CLARIFICATION OF DUTIES PLEASE SUBMIT A COPY OF INSURED'S JOB DESCRIPTION.
5. Work schedule at time of disability: Days per week _____ Hours per day _____
6. When did insured enter your employ? _____
7. (a) When was Insured compelled to give up part of his duties? (Give exact date.) _____

   (b) When was Insured compelled to give up all of his duties? (Give exact date.) _____
8. Is Insured's illness or injury the sole cause of his absence from duty? (Please specify.) If not, give particulars.

   _____

   _____
9. (a) If accident, was Insured injured at work? ☐ Yes ☐ No

   (b) If so, what is the name and address of the compensation carrier? _____

   _____

   _____
10. Has Insured been absent from work before because of any illness or injury? If so, give particulars. (Including exact dates.) _____

    _____

    _____

    _____
11. (a) Is Insured still in your employ? _____ (b) If so, when do you expect him to return to work? _____
12. Name of group medical carrier and policy number: _____

    _____
13. (a) Date Insured returned to work part time. (Give exact date.) _____

    (b) Date Insured returned to work full time. (Give exact date.) _____

_____
SIGNATURE

_____ _____
WITNESS *OFFICIAL POSITION* *TEL. NO.*

_____ _____
DATED *DATED*