

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

Name of Patient/Proposed Insured (Please Print)	Policy	Date of Birth
/ /		

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, American General Life Insurance Company, American International Life Assurance Company of New York, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service company), (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 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 Insured, including name, address, telephone number, gender and date of birth.

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 American General Life Companies 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; and
- the Medical Information Bureau (MIB).

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 companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life 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 Companies Service Center, P. O. Box 4373, Houston, TX 77210-4373. 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 the insured's claim for benefits under 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 the claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under the 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.

Signature of Insured, Insured's Personal Representative, or Beneficiary(s)

Date

Description of Authority of Personal Representative (if applicable)