



American International Life Assurance Company of New York

New York, New York

A member company of American International Group, Inc.

Administrative Office: Policy Benefit-Life Department, 3600 Route 66, P.O. Box 1580, Neptune, NJ 07754-1580

AS REQUIRED BY LAW, 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 ACT, WHICH IS A CRIME.

Statement of Policyholder

Name of Employee		Address of Employee		Amount of Insurance for Dependent	
Group Policy Number	Certificate Number	Name and Address of Employer			Telephone Number
Duration of Employment From: _____ Through _____		Last Day of Full Time Active Work for Employer		Reason for Stopping Work	
Full Name of Deceased Dependent		Relationship to Employee		Dependent's Date of Birth	
Is Dependent Married?	Date of Death	If Contributory Insurance, to What Date has Employee's Contribution Been Paid			
If Full Time Student, Name and Address of School Attended					
Is Dependent Employed Full Time? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name and Address of Dependent's Employer			
Name of Beneficiary		Relationship		Age	
Signature of Policyholder's Official Representative		Title		Current Date	
Print Name of Individual Whose Signature Appears Above		Send Check To			

Claimant's Statement

Full Name of Deceased		Date of Birth	Date of Death
Cause of Death			Place of Death
When did deceased first complain of, or give indication of his last illness? Date		When did deceased first consult a physician for his illness? Date	
In What Capacity do you Claim This Insurance? (If Administrator, executor or guardian, attach copy of court order of appointment.)			
Your date of Birth	Your Social Security Number	If lump-sum settlement is NOT elected, indicate Optional Mode of Settlement desired	

These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force. I hereby authorize and request any hospital, physician, pharmacist, employer, insurance company or other person or entity to whom this is presented to furnish American International Life Assurance Company of New York or its representative, any and all information and records (or copies thereof) it may desire, specifically to include testing and/or treatment of Human Immunodeficiency (HIV) or AIDS, concerning the deceased and further agree that such information or records shall constitute and are hereby made a part of the Proofs of Death. A photostatic copy of this authorization shall be as valid as the original.

Under penalty of perjury, I certify that the Social Security/Tax I.D. number provided on this form is true, correct, and complete. I understand that failure to furnish this number can subject me to back-up withholding. I certify that I am not now subject to back up withholding.

_____	_____
<i>Date</i>	<i>Signature</i>
_____	_____
<i>Witness</i>	<i>Address</i>
_____	_____
<i>Address</i>	<i>Address</i>
_____	_____
<i>Address</i>	<i>Telephone</i>

By furnishing this blank investigating the claim, the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

INSTRUCTIONS

To Avoid Unnecessary Delay In Processing Claims, Please Complete All Blank Areas And Sign Form.

The **STATEMENT OF POLICYHOLDER** should be completed and signed by an authorized representative of the group policyholder (employer, union, association, welfare fund or other organization through which the insurance was obtained).

The **CLAIMANT'S STATEMENT** should be completed and signed by the beneficiary (usually the insured employee). Anyone other than a family member may sign as witness to the beneficiary's signature.

A copy of the **ENROLLMENT FORM**, if available, and a **CERTIFIED** copy of the **DEATH CERTIFICATE** must accompany this form. Submit the claim proofs to:

American International Life Assurance Company of New York
Attention: Policy Benefit-Life Department
3600 Route 66 • PO Box 1580
Neptune NJ 07754 1580