



**AMERICAN
GENERAL**

AIG Life Insurance Company*

Wilmington, Delaware

A member company of American International Group, Inc.

Administrative Office: Policy Benefits-Life/MSN 2-K, 3600 Route 66, PO Box 1580, Neptune, NJ 07754-1580

*This company does not solicit business in New York.

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 INSURANCE ACT, WHICH IS A CRIME.

TO AVOID UNNECESSARY DELAY IN PROCESSING CLAIMS, PLEASE COMPLETE ALL BLANK AREAS AND SIGN FORM.

STATEMENT OF POLICYHOLDER

NAME OF DECEASED EMPLOYEE		ADDRESS OF DECEASED EMPLOYEE		AMOUNT OF INSURANCE	
GROUP POLICY NO.	CERTIFICATE NO.	NAME AND ADDRESS OF EMPLOYER		TELEPHONE NUMBER	
DATE OF EMPLOYEE'S Birth Death		Last day of full time active work for employer			
REASON FOR STOPPING WORK					
<input type="checkbox"/> Illness		<input type="checkbox"/> Leave of Absence		<input type="checkbox"/> Retirement	
				<input type="checkbox"/> Lay Off	
				<input type="checkbox"/> Other (Explain briefly)	
<input type="checkbox"/> Union Employee		<input type="checkbox"/> Full Time			
<input type="checkbox"/> Non-Union Employee		<input type="checkbox"/> Part Time		Average Number of Hours Worked Per Week	
IF DUE TO ILLNESS, DISABILITY BENEFITS WERE PAID					
From		To		Carrier's Name	
DURATION OF EMPLOYMENT		EMPLOYEE'S JOB TITLE		WEEKLY EARNINGS	
From		Through		INSURANCE CLASS	
IF CONTRIBUTORY INSURANCE, TO WHAT DATE HAS EMPLOYEE'S CONTRIBUTION BEEN PAID?					
Date					
BENEFICIARY (IF ESTATE, CERTIFIED COPY OF COURT ORDER APPOINTING EXECUTOR OR ADMINISTRATOR SHOULD BE ATTACHED)					
Name and Address			Relationship		Age
GUARDIAN (IF BENEFICIARY IS A MINOR, A CERTIFIED COPY OF COURT ORDER APPOINTING GUARDIAN SHOULD BE ATTACHED)					
Full Name		Address			
SEND CHECK TO		CURRENT DATE		SIGNATURE OF POLICYHOLDER'S OFFICIAL REPRESENTATIVE	

ATTENDING PHYSICIAN'S STATEMENT

If Decedent Was Disabled More Than 31 Days Prior to Death, Please Have This Statement Completed By The Physician Who Treated During This Disability.

FULL NAME OF DECEASED		DATE OF DEATH		AGE	
PLACE OF DEATH		DATE OF FIRST VISIT		DATE OF LAST VISIT	
IMMEDIATE CAUSE OF DEATH				DURATION	
CONTRIBUTORY CAUSES OR COMPLICATIONS				DURATION	
DEATH RESULTED FROM:					
<input type="checkbox"/> Natural Causes		<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	
				<input type="checkbox"/> Homicide	
IF DUE TO ACCIDENT, SUICIDE, OR HOMICIDE, DESCRIBE BRIEFLY:					
Decedent was totally disabled and unable to perform work from _____ to _____					
I hereby certify that the above answers are true and complete to the best of my knowledge and belief.					
DATE		PRINT NAME			
TELEPHONE NUMBER		SIGNATURE			
ADDRESS					

THE CERTIFICATE OF INSURANCE AND ORIGINAL ENROLLMENT FORM (IF AVAILABLE) SHOULD ACCOMPANY THIS FORM BY FURNISHING THIS BLANK AND 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

(Over)

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? _____ WHEN DID DECEASED FIRST CONSULT A PHYSICIAN FOR HIS LAST ILLNESS? _____

Date _____ Date _____

WAS DEATH THE RESULT OF AN ACCIDENT? _____ DATE OF ACCIDENT _____ PLACE OF ACCIDENT _____ DID ACCIDENT OCCUR IN COURSE OF EMPLOYMENT? _____

Yes No

DESCRIBE ACCIDENT BRIEFLY _____

NAMES AND ADDRESSES OF ALL PHYSICIANS WHO ATTENDED THE DECEASED AND OF ALL HOSPITALS AND INSTITUTIONS WHERE HE WAS TREATED DURING THE LAST ILLNESS AND DURING FIVE YEARS PRIOR THERETO:

Name	Address	Date	Disease or Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FACTS CONCERNING OTHER LIFE, HEALTH AND ACCIDENT INSURANCE CARRIED BY DECEASED.

Company	Policy Number	Amount of Insurance
_____	_____	_____
_____	_____	_____
_____	_____	_____

ORIGINAL CERTIFICATE OF INSURANCE MUST BE RETURNED IF AVAILABLE

Certificate enclosed Certificate cannot be located

IN WHAT CAPACITY DO YOU CLAIM THIS INSURANCE (IF ADMINISTRATOR, EXECUTOR OR GUARDIAN, ATTACH A COPY OF COURT ORDER APPOINTMENT.) _____

YOUR DATE OF BIRTH _____ YOUR SOCIAL SECURITY NUMBER _____ ESTATE TAX I.D./TRUST TAX I.D. (PROVIDE IF CLAIM MADE BY ESTATE OR TRUST) _____

- I elect to receive payment by
- immediate availability of funds from an interest-bearing checking account* with free check-writing privileges.
 - lump sum direct payment by check.
 - other settlement option (Please Specify and if necessary, contact your insurance plan administrator for a description of other settlement options available) _____.

* If your proceeds are eligible and exceed the current applicable minimum (\$5,000) set by the company, an interest-bearing checking account will be established in your name. You may immediately write a check for the full amount or leave your account open and draw money only as you need it. Meanwhile, the funds will earn interest at the variable rate currently effective for the Insurance Company Instant Access Accounts payable through State Street Bank and Trust Company. The Instant Access Account is not available to estates, trusts or guardianships.

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 AIG Life Insurance Company 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. Furthermore, in the event an Instant Access Account is opened, the Signature of Claimant(s) presented on this claim form will be used for signature verification.

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.

DATE _____ PRINT CLAIMANT'S NAME _____

WITNESS _____ SIGNATURE OF CLAIMANT, WITH TITLE, IF ANY _____

ADDRESS _____ ADDRESS _____

ADDRESS _____ ADDRESS _____

DAYTIME TELEPHONE NUMBER _____

By furnishing this blank and 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.