AIG

AIG Benefits Solutions
Underwritten by
American General Life Insurance Company*
Houston, Texas
The United States Life Insurance Company
New York, New York
* This company does not solicit business in New York

Packet Instructions
Administrative Office: P.O. Box M, Beattyville, KY 41311
Phone: 888-762-2250 Fax: 888-598-0575

DISABILITY BENEFITS

This packet contains the forms necessary to apply for Disability benefits. For specific information about your Disability insurance coverage, refer to your group insurance certificate. The certificates are the ultimate authority for Disability claim decisions. If you need other information, please contact your employer's benefit administrator.

EMPLOYEE INSTRUCTIONS:

1. Complete and sign your portion of the claim form.
2. Your treating physician should complete the Attending Physician's Statement. If more than one physician is treating you for your disabling condition, each should complete a form. Additional forms are available from your employer's benefit administrator.
3. Sign and date the Authorization for Release of Information and the Fraud Statement and send them, along with the Employee's Statement, to AIG Benefit Solutions at the address listed below.
4. Maintain a copy of all documents for your records.

EMPLOYER INSTRUCTIONS:*

1. Complete and sign your portion of the claim form.
2. Attach a copy of job description and documentation to support Employee earnings as defined in the certificate.
3. Submit all forms along with required documents.
4. Notify the employee's return to work date.

* If your Policy Number begins with a "V", attach a copy of the employee's Enrollment/Application form.

MAIL/FAX CLAIM TO:

AIG Benefit Solutions
Connecticut Claims Center
P.O. Box M
Beattyville, KY 41311
(888) 762-2250
(888) 598-0575 FAX

OTHER BENEFITS THAT MAY REDUCE YOUR DISABILITY BENEFITS

Other benefits you receive may reduce amount of Disability benefits due you. Your group insurance certificate lists these benefits, which may include, but are not limited to, Sick Leave, Workers' Compensation, State Disability, Social Security and Retirement.

To avoid a possible overpayment of your claim, please inform us if you receive these or other benefits.

WHEN YOU RETURN TO WORK

Your Disability benefits usually stop when you return to work. Be sure that you or your employer notify us immediately when you plan to, or have, returned to work to assure no overpayment occurs.

All portions of this form packet must be completed to avoid undue delay in processing the claimant's request for benefits.

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HIPAA Authorization -
New Business and Inforce Operations

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

Claimant's Name Date of Birth Case Number

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and any affiliated services 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 my health (except psychotherapy notes) and my 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 me, including my 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 International Group (AIG) companies which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my 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 my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the 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 AIG Benefit Solutions® 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: AIG Benefit Solutions®, P.O. Box M, Beattyville, KY 41311 06034-0387. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

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 my application.

This authorization will be valid for 24 months. 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.

_____ Date _____/_____/_____

Signed of Proposed Insured or
Proposed Insured's Personal Representative

_____

Description of Authority of Personal Representative
(If applicable)

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Employee's Statement

Administrative Office: P.O. Box M, Beattyville, KY 41311
Phone: 888-762-2250 Fax: 888-598-0575

TO BE COMPLETED BY THE EMPLOYEE: PLEASE ANSWER ALL QUESTIONS: FAILURE TO DO SO MAY DELAY YOUR CLAIM

First Name	Last Name	Maiden Name, if Applicable	MI

Address	City	State	ZIP

Home Phone Number	Additional Phone Number	Social Security Number	Date of Birth

Gender ☐ Male ☐ Female	Height	Weight	Marital Status: ☐ Single ☐ Married ☐ Divorced

Spouse's Name, if Applicable	Date of Birth	Is Spouse Working? ☐ Yes If Yes, number of hours working ☐ No

Dependents you are responsible for (Check all that apply)
☐ Children under 18 ☐ Children 18-22 attending Elementary or Secondary school full time ☐ Handicapped Children of any age

Name of Child	Date of Birth	Name of Child	Date of Birth

Your Employer's Name	Human Resources Contact	Phone Number

Current Occupation/Job Title at Time of Disability	Job Location	Number of Hours Worked per Week

Last day worked	First day absent from work for this disability	Medical condition preventing you from working

List the signs and symptoms preventing you from working at any job	Date of Injury	Describe Injury

Is the condition work related? ☐ Yes ☐ No	Name of Workers' Compensation Carrier	Phone Number

Do you expect to return to work? ☐ Yes Date ☐ No	Date returned to work full-time to original job	Date returned to work full-time at a different job or same job with modifications	Date returned to work part-time

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date/ End Date
Salary Continuance/Sick Time	☐	☐	☐	☐				
Social Security	☐	☐	☐	☐				
Workers' Compensation	☐	☐	☐	☐				
State Disability	☐	☐	☐	☐				
Retirement or Pension *(Employer, PERS, STRS, PERA, etc.)* Please specify type	☐	☐	☐	☐				
Other _____ (e.g. unemployment, union or no-fault benefits, etc.)	☐	☐	☐	☐				

Were you hospitalized? ☐ Yes ☐ No	Name of Hospital	Date Admitted	Date Discharged

Hospital Address	City	State	ZIP	Phone Number

If disability is the result of pregnancy or childbirth: Expected Date of Delivery _____ Actual Date of Delivery _____

Type of delivery: ☐ Normal ☐ C-Section	Post-Partum Complications: ☐ Yes ☐ No If Yes, please describe:

Attending Physician's Name			Specialty	
Address		City	State	ZIP
Phone Number		Fax Number		
First Office Visit	Last Office Visit		Next Office Visit	

List Additional Providers Name	Phone Number	Fax Number	First Office Visit	Last Office Visit	Next Office Visit
1.					
2.					
3.					

Current Medications			
Pharmacy Name			Phone Number
Address	City	State	ZIP
LEVEL OF EDUCATION			

High School Graduate	☐ Yes ☐ No	If No, last grade completed	
College Graduate	☐ Yes ☐ No	Degree	Major
Post Graduate	☐ Yes ☐ No	Degree	Major

Other Certificates/Technical Training

Have you attended, or are you currently attending any trade schools or received other special training? ☐ Yes ☐ No If Yes, please describe

Were you in the Armed Forces? ☐ Yes ☐ No Branch of Service _____ Highest Rank _____ Specialty _____

List prior or current employers including self employment	From	To	Salary	Job Title/Physical Requirements
1.				
2.				
3.				

List any interests or hobbies

If you also have Life coverage with us complete the following:
Please consider this an application for waiver of premium under my Life Insurance: ☐ Yes ☐ No

ACKNOWLEDGEMENT

With the exception of any source(s) of income reported on this form, I certify by my signature that I have not and am not eligible to receive any source of income, expect for my AIG Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period AIG has approved my disability claim, I must report all details to AIG immediately.

If I receive disability income benefits greater than those which should have been paid, I understand that I will be responsible to provide repayment to AIG. AIG has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

_____ _____

Signature* **Date**

***Please sign and date the Authorization for Release of Information and the Fraud Statement and include them with this form.**

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Employer's Statement

Administrative Office: P.O. Box M, Beattyville, KY 41311
Phone: 888-762-2250 Fax: 888-598-0575

TO BE COMPLETED BY THE EMPLOYER: ***Attach a copy of the Employee's Job Description***

Employer Name	Policy Number	Class/Plan

Employee First Name	Employee Last Name	Social Security Number	Other AIG Coverages ☐ STD ☐ LTD ☐ Life ☐ Income Plus	Policy #

Date of hire	Employee's plan effective date	Did the employee have prior plan coverage? ☐ Yes ☐ No	Name of Carrier

Work status prior to disability ☐ Full-Time (_____) hours ☐ Part-Time (_____) hours	Last day employee worked	First date absent	Reason employee stopped working

Status as of first day absent: ☐ Active ☐ Vacation ☐ LOA ☐ Laid Off ☐ Retired ☐ Terminated	Date returned to work full time to original job	Date returned to work part time

Employee's earnings $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annual	Additional Earnings ☐ Commission ☐ Other	Date of last salary increase

Has the employee applied for or is he/she receiving benefits from	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date/ End Date
Salary Continuance / Sick Time	☐	☐	☐	☐				
Social Security	☐	☐	☐	☐				
Workers' Compensation	☐	☐	☐	☐				
State Disability	☐	☐	☐	☐				
Retirement or Pension *(Employer, PERS, STRS, PERA, etc.)* Specify Type _____	☐	☐	☐	☐				
FMLA	☐	☐	☐	☐				
Other _____ (e.g. unemployment, union or no-fault benefits, etc.)	☐	☐	☐	☐				

Is this condition work related? ☐ Yes ☐ No	Name of Workers' Compensation Carrier	Phone Number	Contact Person

List any other source of income to which the employee is entitled as a result of this disability

Percentage of employee contribution to disability premium _____%	Employee's contributions were made ☐ Pre tax ☐ Post tax	Premium paid through date for this employee

Is employee eligible for Group Pension? ☐ Yes ☐ No Monthly amount: _____	Percentage of employee contribution to Group Pension _____%	Effective date

Employee's job is ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy	Occupation/Job Title prior to disability

In a work day given two breaks and a meal break, the employee must:
Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+
Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total hours	With positional change
Sit	8 7 6 5 4 3 2 1	*(hrs)* _____
Stand	8 7 6 5 4 3 2 1	*(hrs)* _____
Walk	8 7 6 5 4 3 2 1	*(hrs)* _____
Alternately Sit/Stand	8 7 6 5 4 3 2 1	*(hrs)* _____

Reach above shoulder	☐ Never	☐ Occasionally	☐ Frequently
Climb	☐ Never	☐ Occasionally	☐ Frequently
Crawl	☐ Never	☐ Occasionally	☐ Frequently
Bend/stoop	☐ Never	☐ Occasionally	☐ Frequently

Drive cars, trucks, forklifts and/or other equipment: ☐ Yes ☐ No
Be around moving equipment: ☐ Yes ☐ No
Walk on uneven ground: ☐ Yes ☐ No

Can employee's job be modified? ☐ Yes ☐ No Please explain: _____

I HEREBY CERTIFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF:

Employer Signature	Title	Date

Phone Number	Fax Number	Email Address

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Attending Physician's Statement

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Phone: 888-762-2250 Fax: 888-598-0575

TO BE COMPLETED BY THE EMPLOYEE:

First Name	Last Name	Date of Birth

Employer Name	Current Occupation

TO BE COMPLETED BY THE ATTENDING PHYSICIAN *Provide Copies of Medical Records, Consultative Reports and Diagnostic Tests*

Primary Diagnosis	ICD-9	Secondary Diagnosis	ICD-9

Symptoms	Height	Weight	B/P	Dominant Side ☐ Right ☐ Left

PREGNANCY *(if applicable)*

Expected date of delivery	Actual date of delivery	Type of delivery ☐ Normal ☐ C-section

Significant complications, if any (ante-partum/post-partum)

HISTORY

Patient referred by	Phone number

Date of first visit	Date(s) of subsequent visits	Date of most recent visit	Date of next visit

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If Yes, when?

Is this condition related to the patient's employment? ☐ Yes ☐ No	Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No
When did symptoms first appear or injury happen?	Date you advised the patient to cease/and or modify work activity

Planned course and duration of treatment *(include surgery and medications, if any)*

HOSPITALIZATION *(if applicable) Attach admission and discharge summaries*

Date admitted	Reason	

Name of Hospital	Address	City	State	ZIP

PROGNOSIS

Since onset of symptoms, the patient's condition has: ☐ Improved ☐ Not changed ☐ Retrogressed

PHYSICAL IMPAIRMENT *(*As defined in Federal Dictionary of Occupational Titles)*

☐ Class 1 No limitation of functional capacity; capable of heavy work* no restrictions (0-10%)
☐ Class 2 Medium manual activity* (15-30%)
☐ Class 3 Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity* (60-70%)
☐ Class 5 Severe limitation of functional capacity; incapable of minimal (sedentary) activity* (75-100%)

In a work day given two breaks and a meal break, the patient can:
Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+
Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total hours	With positional change
Sit	8 7 6 5 4 3 2 1	*(hrs)* _____
Stand	8 7 6 5 4 3 2 1	*(hrs)* _____
Walk	8 7 6 5 4 3 2 1	*(hrs)* _____
Alternately Sit/Stand	8 7 6 5 4 3 2 1	*(hrs)* _____

Reach above shoulder	☐ Never	☐ Occasionally	☐ Frequently
Climb	☐ Never	☐ Occasionally	☐ Frequently
Crawl	☐ Never	☐ Occasionally	☐ Frequently
Bend/stoop	☐ Never	☐ Occasionally	☐ Frequently

Drive cars, trucks, forklifts and/or other equipment: ☐ Yes ☐ No
Be around moving equipment: ☐ Yes ☐ No
Walk on uneven ground: ☐ Yes ☐ No

CARDIAC *(if applicable) Functional Capacity (American Heart Association)*
☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
Blood Pressure (latest reading)_____/_____ as of_____Date Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

MENTAL/NERVOUS *(if applicable)*
Define "stress" as it applies to this patient

What effect has stress and, or problems in interpersonal relations had on the patient's ability to perform her/his job functions, if any?

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (No Limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (Slight Limitations)
☐ Class 3 – Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations (Moderate Limitations)
☐ Class 4 – Patient is not able to engage in stress situations or engage in interpersonal relations (Marked Limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Severe Limitations)

Axis I _____ Axis II _____ Axis III _____ Axis IV _____

Most recent GAF Score _____ Date of assessment _____ Highest GAF Score in the last year _____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

REHABILITATION/RETURN TO WORK When could trial employment begin?

PATIENT'S JOB:	**ANY OTHER WORK:**
☐ Full-time ☐ Part-time Date _____	☐ Full-time ☐ Part-time Date _____
☐ Unable to Determine: Follow-up in _____ weeks	☐ Unable to Determine: Follow-up in_____weeks
☐ Never	☐ Never

Would job modification enable patient to work with impairment? ☐ Yes ☐ No If Yes, explain under Remarks.

Is the patient a suitable candidate for: (check as many as apply)

☐ Physical Therapy	☐ Cardiac Rehabilitation Program	☐ Work Hardening Program
☐ Occupational Therapy	☐ Cardiopulmonary Program	☐ Job Modification
☐ Speech Therapy	☐ Pain Management Program	☐ Other
☐ Vocational Rehabilitation	☐ Psychological Counseling	
Was this discussed with the patient?	☐ Yes ☐ No	

Are you aware of any other disability income policies? ☐ Yes ☐ No If Yes, list Insurance Company Name and Policy Number

Insurance Company Name _____	Policy Number _____
Insurance Company Name _____	Policy Number _____

REMARKS

OTHER TREATING PHYSICIANS OR CONSULTANTS

Physician Name	Specialty	Phone Number

Name of Physician Completing This Form (Print)			Phone Number
Specialty	Tax ID Number		Fax Number
Address	City	State	ZIP

I HEREBY CERTIFY THAT THE ANSWERS I HAVE MADE TO THE FOREGOING QUESTIONS ARE BOTH COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature	Date

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Fraud Statement

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Phone: 888-762-2250 Fax: 888-598-0575

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:
Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: 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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF INSURED _____ DATE _____