AMA INSURANCE

DISABILITY • LIFE • HEALTH • RETIREMENT

The United States Life Insurance Company in the City of New York
New York, New York

Mail your claims to: AMA Insurance Agency, Inc.
Claims Department
PO Box 10746
Chicago, IL 60610-0746

Policy No. E– | | | | | | | |

Certificate Number | | | | | | | | | | |

Insured's Social Security Number | X | X | X | – | X | X | – | | | | |

Name of Insured (first, middle initial, last) (Please Print)				
Insured's Address, Street & No.			City	State / Zip
Phone No.	Date of Birth	Male ○ Female ○	Employed At:	
Single ○ Divorced ○ Other ○ Married ○ Widowed ○	If Married, Spouse's Name		Spouse's Date of Birth	
Patient's Name for whom claim is being made (first, middle initial, last)			Patient's Relationship to Insured	Single ○ Married ○
Patient's Address, Street & No.			City / State / Zip	
Patient's Sex Male ○ Female ○	Patient's Date of Birth	If over age 21 and attending school or college, give name and address of school		
Nature of Sickness or Injury	Date first treated for this condition	Is condition related to employment? Yes ○ No ○ Is condition related to an auto accident? Yes ○ No ○		
If related to an injury, how, when and where did the injury occur?				
If hospitalized, give name and address of hospital			Dates of confinement	
Treating Physician's Name	Treating Physician's Telephone Number			
Treating Physician's Address, Street & No.			City / State / Zip	

Please indicate by checking yes or no and providing the policy number if you and/or the patient have coverage under any of the following plans.

Medicare - Yes ○ No ○ Policy # _____ GHI - Yes ○ No ○ Policy # _____

Aetna - Yes ○ No ○ Policy # _____ United HealthCare - Yes ○ No ○ Policy # _____

BlueCross - Yes ○ No ○ Policy # _____ AARP - Yes ○ No ○ Policy # _____

Please list all other coverages you and/or the patient may have.

Policy # _____ Insurance Co. Name & Address

Policy # _____ Insurance Co. Name & Address

Policy # _____ Insurance Co. Name & Address _____

_____ Signature of Insured

_____ Date

AMA INSURANCE

DISABILITY • LIFE • HEALTH • RETIREMENT

The United States Life Insurance Company in the City of New York
New York, New York

HIPAA Authorization
Claims

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number XXX–XX– __ __ __ __

I hereby authorize all of the people and organizations listed below to give 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, as well as other 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; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company 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 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 AIG American General 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: AMA Insurance Agency, Inc., Claims Department, P.O. Box 10746, Chicago, IL 60610-0746. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my 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 my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my 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 or Insured's Personal Representative

Date

Description of Authority of Personal Representative (if applicable)