American Income Life Insurance Company

P.O. Box 2500 • Waco, Texas 76797

CLAIMANT'S STATEMENT

Please carefully read all of the following information before completing this statement.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, Louisiana, Rhode Island, Texas and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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 that you be made aware of the following: 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 a 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 for the purpose of defrauding or attempting to defraud the 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 or 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.

Hawaii: For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana: Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly or 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.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

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

New Mexico: Any person who knowingly presents a false of fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

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.

Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AMERICAN INCOME LIFE INSURANCE COMPANY

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INSTRUCTIONS FOR SUBMITTING AN ACCIDENT, HEALTH OR DISABILITY/WAIVER OF PREMIUM CLAIM

Accident & Illness Claims - Complete Part A and Part E for all Claims, and Part B if policy is less than 2 years old

- ☐ For US Only - Include a copy of all itemized Hospital/Doctor bills and Proof of Treatment which include procedure and diagnosis codes.
- ☐ For Canada Only - Have the doctor complete Part D - 'Attending Physician's Statement', and attach verification of treatment for services received.

Cancer Claims - Complete Part A for all Claims, and Complete Part B if policy is less than 2 years old

- ☐ A Pathology Report must be included in the initial claim for the diagnosis of Cancer.
- ☐ For US Only - Submit any Hospital/Doctor bills related to the treatment of Cancer which include procedure and diagnosis codes.
- ☐ For Canada Only - Have the doctor complete Part D - 'Attending Physician's Statement', and attach verification of treatment for services received in relation to the claim.

Disability or Waiver of Premium Claims - Complete Part A for all Claims, and Complete Part B if policy is less than 2 years old

- ☐ Have your Employer Complete Part C - 'Employers Statement'.
- ☐ Have the doctor complete Part D - 'Attending Physician's Statement'.

Part A - To be Completed by the Insured for all Claims

Policy Numbers | | |

Policyowner's Name

Policyowner's Mailing Address

Policyowner's Employer

Policyowner's Union and Local# *(If Union member)*

Policyowner's Occupation

Policyowner's Email Address

Policyowner's Phone #

Patient's Name

Patient's Date of Birth

Patient's Gender ☐ Male ☐ Female

Patient's Relationship to Policyowner ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Does patient have any other insurance coverage which provided benefits for this claim? ☐ No ☐ Yes
If yes, Name:_____

1. This Claim is in Connection with: (please check)
☐ Accident ☐ Illness ☐ Cancer ☐ Disability/Waiver of Premium

Was patient confined to hospital due to Accident/Illness claim? ☐ No ☐ Yes

2 . Date of Accident/Illness

3 . Date First Treated

4 . Nature of Injury/Illness sustained & how it happened

5. Name & Address of Provider treating this condition

Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to the American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

American Income Life Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name below, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge.

Patient's Signature _____ Date _____

Part B - Health Information — ONLY COMPLETE IF POLICY IS LESS THAN 2 YEARS OLD

List all sickness or injuries and physicians for which treatment was required in the past 5 years

Physician & Address	Condition	Date Symptoms Appeared	Date of Initial Treatment	Date Diagnosed

Part C - To be Completed by the Employer — DISABILITY OR WAIVER OF PREMIUM ONLY

Employee's Name	Occupation
When did sickness or accident occur?	When did he/she cease work?

If injured, how did it happen?

When did employee resume any part of employee's work, supervisory or other?

Company Name	Phone Number

Street Address	City	State	Zip

Signature of Employer _____ Date _____

Title _____

Part D - To be Completed by the Attending Physician

Patient's Name	Patient's Address
Patient's Date of Birth	
Diagnosis and current conditions: (If diagnosis code other than international classification of diseases, give name)	Does condition arise out of patient's employment? ☐ Yes ☐ No
	If Condition due to pregnancy, date pregnancy commenced

REPORT OF SERVICES (or attach itemized bill)

Date of Services	Place of Services	Description of Surgical or Medical Services	Procedural Code (Give name if not current terminology)	Charges
			TOTAL CHARGES	

IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL AND DATES OF CONFINEMENT

Hospital	Address	Dates

Result of an Accident? ☐ Yes ☐ No	Date of Accident?
Date patient first consulted you for this condition	Patient still under your care for this condition? ☐ Yes ☐ No
Patient ever had similar condition? ☐ Yes ☐ No If yes, when:	Was patient referred to you? ☐ Yes ☐ No If yes, name and address of referring physician
Patient was continuously TOTALLY DISABLED (unable to work) From To	Patient was PARTIALLY DISABLED From To
If still disabled, date patient should be able to return to work	Does patient have any other health coverage? ☐ No ☐ Yes If yes, Name:

Please give name and address of any physicians or other practitioners you referred the patient to see

Name	Address	Phone

Physician's Name (Please print) _____

Physician's Address _____ Phone _____

Signature of Physician _____ Date _____

Part E - AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Insured's Name	Date Of Birth	Social Security Number	Policy Number
Insured's Address			

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, Medical Information Bureau (MIB), or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the American Income Life Insurance Company (AIL) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that AIL may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with AIL.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to AIL, Attention: Claims Department, at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that AIL has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, AIL may not be able to process my claim or make any benefit payments. I have received a copy of this authorization.

Name and address of person(s) or category of person to whom this information will be sent	Name of person signing form:
American Income Life PO Box 2500 Waco, TX 76797	

Authority to sign on behalf of Insured.

☐ Parent ☐ Legal Guardian ☐ Child ☐ Spouse ☐ Next of Kin

☐ Executor of Estate ☐ Other (please specify relationship to Insured) - _____

All items on this form have been completed and my questions about this form have been answered. American Income Life Insurance Company and I agree that this Claimant's Statement may be electronically signed. By typing my name below, I hereby agree that my electronic signature shall have the same effect as if it were handwritten. Further, I hereby attest that the information given herein is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient/Beneficiary/Guardian or Personal Representative Date

Please make a copy of this authorization and retain for your record.