AIG

Attending Dentist's Statement

American General Life Insurance Company
Houston, Texas
The United States Life Insurance Company in the City of New York
New York, New York
MAIL TO: P.O. Box 1581, Neptune, NJ 07754-1581

Complete, sign and date your portion of the form including the Authorization for Release of Information and Fraud Statement and send all documents to the above address.

PATIENT SECTION

Check One: ☐ **Dentist's pre-treatment estimate** ☐ **Dentist's statement of actual services**

1. Patient name First / M.I. / Last	2. Relationship to Employee ☐ self ☐ child ☐ spouse ☐ other_____	3. Sex M F	4. Patient birthdate MO DAY YR	5. If full-time student School / City
6. Employee/Subscriber name and mailing address	7. Employee/Subscriber soc. sec. number	8. Employee/Subscriber birthdate MM DD YYYY	9. Employer (Company) Name and Address	10. Group Number
11. Is Patient covered by another plan of benefits? Dental _____ Medical _____	12-A. Name and address of carrier(s)	12-B. Group no.(s)	13. Name and Address of employer	
14-A. Employee/Subscriber name (if different than patient's)	14-B. Employee/Subscriber Soc. sec. number	14-C. Employee/Subscriber birthdate MO DAY YR	15. Relationship to Patient ☐ self ☐ child ☐ spouse ☐ other_____	

I have reviewed the following treatment plan. I understand that I am responsible for all costs of dental treatment.

▶ _____ _____
Signed (Patient, or parent if minor) Date

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

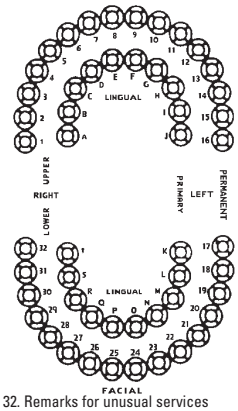
▶ _____ _____
Signed (Insured person) Date

DENTIST SECTION

16. Dentist Name	24. Is treatment result of occupational illness or or injury?	No	Yes	If Yes, enter brief description and dates.
17. Mailing Address	25. Is treatment result of auto accident?			
	26. Other accident?			
City, State, Zip	27. Are any services covered by another plan?			
18. Dentist Soc. Sec. or T.I.N. 19. Dentist License no. 20. Dentist Phone no.	28. If prosthesis Is this initial placement?			(If no, reason for replacement) 29. Date of prior placement
21. First visit date current series. 22. Place of treatment Office Hosp. ECF. Other 23. Radiographs or models enclosed? No Yes How many?	30. Is treatment for orthodontics?			If services already commenced, enter. Date appliances placed. Mos. treatment remaining?

Identify missing teeth with "x"

FACIAL



32. Remarks for unusual services

31. Examination and treatment plan — list in order from tooth no. 1 through tooth no. 32 — use charting system shown.

	Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.) Line No.	Date service performed mo. day year	Procedure number	Fee	For administrative use only
			1	/ /			
			2	/ /			
			3	/ /			
			4	/ /			
			5	/ /			
			6	/ /			
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			16	/ /			
			17	/ /			
			18	/ /			
			19	/ /			
			20	/ /			

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures

▶ _____ Date: _____
Signed (Dentist)

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier #	
Carrier pays	
Patient pays	

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Authorization for Release of Information

American General Life Insurance Company
Houston, Texas
The United States Life Insurance Company in the City of New York
New York, New York
MAIL TO: P.O. Box 1581, Neptune, NJ 07754-1581

CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I hereby authorize all of the people and organizations listed below to give AG Life Insurance Company, 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, 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; 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 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 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: American General, P.O. Box 1581, Neptune, NJ 07754-1581. 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.

_____

NAME OF CLAIMANT (PRINT)

_____ _____

SIGNATURE OF CLAIMANT/GUARDIAN/REPRESENTATIVE DATE

AIG

Fraud Statement

American General Life Insurance Company
Houston, Texas
The United States Life Insurance Company in the City of New York
New York, New York
MAIL TO: P.O. Box 1581, Neptune, NJ 07754-1581

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 CLAIMANT/GUARDIAN/REPRESENTATIVE DATE