TAB 21

Disability Insurance
Group Long-Term Disability Insurance

Help protect your income when you can't work

For the employees of Louisiana State University Health Sciences Center

Policies issued by:
American General Life Insurance Company
The United States Life Insurance Company in the City of New York
Why Long-Term Disability Insurance?
If an illness or injury left you unable to work for an extended period of time, it could become extremely difficult to cover even your most basic expenses. Although you may have enough money in the bank to meet your immediate needs, what would happen if you were unable to work for months, or even years? The real value of disability insurance lies in the ability to protect you over the long haul.

How Does Long-Term Disability Insurance Work?
If an illness or injury prevented you from working for several months or more:
• Keeping up with important payments for rent or mortgage, utilities, food, tuition, and other expenses could be a struggle without your paycheck — and you may face additional out-of-pocket medical costs for ongoing treatment and care.
• The benefit from your Group Long-Term Disability (LTD) insurance can give you the income you need to help maintain your lifestyle.

Group LTD insurance helps replace income you relied on to meet everyday needs.

What Can Long-Term Disability Insurance Offer Me?

Added Security
• Pays a monthly benefit to you, based on a percentage of your earnings.
• Includes a series of return-to-work features and programs to provide you with support when you need it most:
  – Rehabilitation program includes rehabilitation benefits and child care expenses.
  – Workplace modifications include customizing tools or equipment (e.g., raising or lowering desks), or making ergonomic changes.
• Should you pass away while receiving long-term disability benefits, your benefits will be provided to your eligible survivor for a period of time after your death.

Convenience and Flexibility
• Benefits can be deposited directly into your bank or credit union account.
• Dedicated claims operation assists you with successful recovery and re-entry into the workplace.
• Experienced vocational rehabilitation professionals provide you with an individually tailored program designed to fit your needs.

Ethan’s Story
When a serious accident left Ethan unable to work for 10 months, the loss of income could have been devastating. Since the injury occurred off the job, it wasn’t covered by his workers’ compensation plan, and several of his medical expenses weren’t covered by his health policy. Fortunately, Ethan’s Group Long-Term Disability coverage provided a monthly benefit of $2,200, allowing him to continue meeting his financial obligations until he was able to return to work.
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Plan Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Eligibility</td>
<td>Active, full-time eligible employees working a minimum of 30 hours per week, working and residing in the U.S.</td>
</tr>
<tr>
<td>Waiting Period</td>
<td>None</td>
</tr>
<tr>
<td>Benefit Percentage</td>
<td>60 percent of basic monthly earnings</td>
</tr>
<tr>
<td>Minimum Monthly Benefit</td>
<td>Greater of $100 or 10% of the gross monthly benefit</td>
</tr>
<tr>
<td>Maximum Monthly Benefit</td>
<td>$5000</td>
</tr>
<tr>
<td>Benefit Duration</td>
<td>To Social Security Normal Retirement Age (SSNRA)</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>90 Days</td>
</tr>
<tr>
<td>Definition of Disability During the Elimination Period</td>
<td>Zero-day residual</td>
</tr>
<tr>
<td>Pre-Existing Condition Exclusion</td>
<td>12/12</td>
</tr>
<tr>
<td>Waiver of Disability Premium</td>
<td>Included</td>
</tr>
<tr>
<td>Rehabilitation Program</td>
<td>Included</td>
</tr>
<tr>
<td>Partial Disability Provision</td>
<td>Proportionate loss</td>
</tr>
<tr>
<td>Return-to-work incentive</td>
<td>Included for the first 12 months of disability</td>
</tr>
<tr>
<td>Survivor Benefit</td>
<td>Three times monthly disability payment after 180 days of disability</td>
</tr>
<tr>
<td>Regular Occupation Period</td>
<td>24 months</td>
</tr>
<tr>
<td>Mental/nervous, drug and alcohol limitation</td>
<td>24 months lifetime</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)²</td>
<td>Telephonic EAP with online Work/Life services</td>
</tr>
</tbody>
</table>
This valuable benefit is provided to you by your employer and you will automatically be enrolled.

For more information, please contact:
Stephanie Galendez
504-568-4008
sgalen@lsuhsc.edu

Definitions

- **Benefit duration**: The longest period of time that benefits may continue to be paid to you during a period of disability.
- **Elimination period**: A specified number of days for which you must remain continuously disabled before benefits are payable.
- **Gainful occupation**: If you are disabled from all gainful occupations, based on your education, training, experience and earnings potential, disability benefits will be paid.
- **Mental/nervous, drug and alcohol limitation**: Limit on the period of time over which LTD benefits will be paid when you are disabled from a mental, emotional, nervous, drug or alcohol-related condition that is being treated on an outpatient basis.
- **Partial disability provision**: If you become disabled (non-work related injury or sickness) and can work part-time, you may be eligible for partial disability benefits, which will help you supplement your income until you are able to return to work full time.
- **Regular occupation period**: As long as you are disabled from your regular occupation, disability benefits will be paid.
- **Rehabilitation program**: An organized effort by American General Life Companies and/or your employer to assist you in assuming constructive job duties while recovering. Programs may include temporary limited hours, modified job duties or transitional jobs, as well as permanent accommodations including modified or alternate jobs.
- **Return to work**: For the first 12 months of benefits, your partial disability provision allows you to earn up to 100 percent of pre-disability income, between your work earnings and LTD benefit.
- **Survivor benefit**: Should you pass away while receiving LTD benefits, a lump-sum benefit will be provided to your eligible survivor.
- **Waiting period**: The time determined by your employer before your insurance becomes effective.
- **Waiver of disability premium**: The premium for your long-term disability coverage will be waived while you are receiving benefits.
- **Zero-day residual**: Provision allowing an employee who has been partially disabled to work on a part-time basis immediately, while continuing to satisfy the elimination period.

1. Presented for illustrative purposes only.
2. Provides online access to work/life resources and retail discounts from Work & Family Benefits, Inc. — all at no additional cost. Not an insurance product.

Policies issued by:
**American General Life Insurance Company**
Houston, Texas
Policy form number: G-DIS-41000

**The United States Life Insurance Company in the City of New York**
New York, New York
Policy form number: G-DIS-31000

www.aigbenefits.com

AIG Benefit Solutions® is the marketing name for the domestic benefits division of American International Group, Inc. Louisiana State University Health Sciences Center is a separate and unrelated entity.

The underwriting risks, financial and contractual obligations, and support functions associated with products issued by American General Life Insurance Company and The United States Life Insurance Company in the City of New York are the issuing insurer’s responsibility. The United States Life Insurance Company in the City of New York is authorized to conduct insurance business in New York. Not all policies are available in all states.

This is a summary only of products and services offered. Actual offerings may vary by group size and are subject to state insurance law, and the benefits/provisions as described may vary due to such law. All products are subject to the terms, conditions, limitations and exclusions of the policy. Please see policy and certificate for details.

If applicable, any rates shown are based on the information provided at the time of quoting and are subject to adjustment in the event such information changes.

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AIGB10004BDOD RO4/13

Employer-funded plan

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**Pre-existing Conditions and Exclusions**

(possible variations may apply)

Pre-existing condition means an injury or sickness that occurred within three months just before the effective date of coverage, or the effective date of any individually elected increase under the group policy, or the effective date of an increase due to a policy amendment for which the insured:

- Incurred charges.
- Received medical treatment, consultation, care or services, including diagnostic measures.
- Took prescribed drugs or medicines.

If a disability is due to, caused by or contributed to by a pre-existing condition, and it begins in the first 12 months after the effective date of coverage, or the effective date of any individually elected increase under the group policy, or the effective date of an increase due to a policy amendment, no benefits will be paid.

**Exclusions and Assumptions**

- Evidence of insurability is required for all late entrants.
- The group policy does not cover any disability caused by, contributed to by or resulting from:
  - Loss of professional license, occupational license or certification.
  - Intentionally self-inflicted injuries, while sane or insane.
  - Active participation in a riot.
  - Attempting to commit a crime, or commission of a crime for which the insured has been convicted under federal or state law.
  - Insurrection, war, declared or undeclared, or any act of war.
- The company will not pay a benefit for any period of disability during which the insured is incarcerated as a result of a conviction.

Monthly benefit based on a percentage of employee earnings or flat amount, if elected. The Certificate of Insurance will provide details on benefit percentages, rates, effective date of coverage and other important coverage information. The monthly benefit will be reduced by the amount of any income the insured received or is entitled to receive that month from sources including Federal Social Security Act or the Railroad Retirement Act, the disability sickness laws of any state, workers’ compensation, or a mandatory state auto reparation, or indemnity act (no-fault insurance, where allowed by law). Please see the Certificate of Insurance for additional reduction sources.
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 Employee Benefits Disability Claims Center 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 payroll records for the 3 months preceding disability.
3. Submit all forms along with required documents to the Employee Benefits Disability Claims Center at the address listed below.
4. Notify Employee Benefits Disability Claims Center of 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:
AG Benefit Solutions Connecticut Claim CenterSM
PO. Box 387
Farmington, CT 06034-0387
(888) 762-2250
(888) 598-0575 FAX

OTHER BENEFITS THAT MAY REDUCE YOUR DISABILITY BENEFITS

Other benefits you receive may reduce the 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.
**Employee’s Statement**

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Maiden Name, if Applicable</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone Number</th>
<th>Additional Phone Number</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Height</th>
<th>Weight</th>
<th>Marital Status:</th>
<th>Date of Birth</th>
<th>Is Spouse Working?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td>Single</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td>Married</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Divorced</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse's Name, if Applicable</th>
<th>Date of Birth</th>
<th>Is Spouse Working?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Date of Birth</th>
<th>Name of Child</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your Employer’s Name</th>
<th>Human Resources Contact</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Occupation/Job Title at Time of Disability</th>
<th>Job Location</th>
<th>Number of Hours Worked per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last day worked</th>
<th>First day absent from work for this disability</th>
<th>Medical condition preventing you from working</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List the signs and symptoms preventing you from working at any job

<table>
<thead>
<tr>
<th>Date of Injury</th>
<th>Describe Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the condition work related?</th>
<th>Date of Injury</th>
<th>Name of Workers’ Compensation Carrier</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you expect to return to work?</th>
<th>Date returned to work full-time to original job</th>
<th>Date returned to work full-time at a different job or same job with modifications</th>
<th>Date returned to work part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Were you hospitalized?</th>
<th>Yes</th>
<th>No</th>
<th>Name of Hospital</th>
<th>Date Admitted</th>
<th>Date Discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Type of delivery:</th>
<th>Normal</th>
<th>C-Section</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Post-Partum Complications: [ ] Yes [ ] No If Yes, please describe:

[ ] 06673412-9006 R11/10
<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Fax Number</th>
<th>First Office Visit</th>
<th>Last Office Visit</th>
<th>Next Office Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**List Additional Providers**

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, except for my American General Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period American General has approved my disability claim, I must report all details to American General 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 American General. American General 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.

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Signature*   Date

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

I hereby authorize all of the people and organizations listed below to give AG Life Insurance Company of Delaware, American International Life Assurance Company of New York, 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 Life 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 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 Life Companies 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 AG Benefit Solutions Connecticut Claim CenterSM, PO. Box 387, Farmington, CT 06034-0387. 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
**Employer’s Statement**

**American General Life Insurance Company of Delaware**

**American International Life Assurance Company of New York**

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

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

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Policy Number</th>
<th>Class/Plan</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employee First Name</th>
<th>Employee Last Name</th>
<th>Social Security Number</th>
<th>Other AIG Coverages</th>
<th>Policy Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of hire</th>
<th>Employee’s plan effective date</th>
<th>Did the employee have prior plan coverage?</th>
<th>Name of Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work status prior to disability</th>
<th>Last day employee worked</th>
<th>First date absent</th>
<th>Reason employee stopped working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Time (______) hours</td>
<td>Part-Time (______) hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status as of first day absent:</th>
<th>Date returned to work full time to original job</th>
<th>Date returned to work part time</th>
<th>Date of last salary increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>Vacation</td>
<td>LOA</td>
<td>Laid Off</td>
</tr>
</tbody>
</table>

Employee’s earnings $ ___________ □ Hourly □ Weekly □ Monthly □ Annual □ Commission □ Other

Has the employee applied for or is he/she receiving benefits from:
- 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:
- Social Security
- Salary Continuance / Sick Time
- Retirement or Pension (Employer, PERS, STRS, PERA, etc.)
- FMLA
- Other __________________________

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

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

<table>
<thead>
<tr>
<th>Sit 8 7 6 5 4 3 2 1 (hrs)</th>
<th>Stand 8 7 6 5 4 3 2 1 (hrs)</th>
<th>Walk 8 7 6 5 4 3 2 1 (hrs)</th>
<th>Alternately Sit/Stand 8 7 6 5 4 3 2 1 (hrs)</th>
</tr>
</thead>
</table>

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

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

---

Mail or Fax To: AG Benefit Solutions Connecticut Claim CenterSM P.O. Box 387 Farmington, CT 06034-0387 (888) 598-0575 Fax

American General Life Insurance Company of Delaware
New York, New York

American International Life Assurance Company of New York
New York, New York

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

06673412-9006 R1/10
### PREGNANCY (if applicable)

- Expected date of delivery
- Actual date of delivery
- Type of delivery: Normal, C-section

### 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

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

### HOSPITALIZATION (if applicable)

- Name of Hospital
- Address
- City
- State
- Zip Code
- Date admitted
- Reason
- Date discharged

### 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)
  - Carry (in pounds)
  - Reach above shoulder
  - Climb
  - Crawl
  - Bend/stoop
  - Drive cars, trucks, forklifts and/or other equipment
  - Be around moving equipment
  - Walk on uneven ground

- Total hours
- With positional change
- (hrs)

- Sit 8 7 6 5 4 3 2 1
- Stand 8 7 6 5 4 3 2 1
- Walk 8 7 6 5 4 3 2 1
- Alternately 8 7 6 5 4 3 2 1

- Reach above shoulder
- Climb
- Crawl
- Bend/stoop
- Drive cars, trucks, forklifts and/or other equipment
- Be around moving equipment
- Walk on uneven ground
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

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

REHABILITATION/RETURN TO WORK  When could trial employment begin?

PATIENT’S JOB:
☐ Full-time  ☐ Part-time  Date ___________  ☐ Unable to Determine: Follow-up in ________ weeks
☐ Never

ANY OTHER WORK:
☐ Full-time  ☐ Part-time  Date ___________  ☐ Unable to Determine: Follow-up in ________ weeks
☐ 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 Code

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
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 ____________________
Notice of Conversion

If your group long term disability policy contains a conversion privilege, and your insurance under that policy ends because of your termination of employment, you may be eligible to convert your insurance. To do so, you must:

1. complete and sign the attached application; and
2. forward the signed application along with the first quarterly premium within 31 days of the date your employment terminates.

You are eligible to convert your long term disability insurance if you meet all of the following rules:

• you were insured by the group policy when your insurance terminated;
• your insurance under the group policy ceased solely because of your termination of employment; and
• you were insured for twelve consecutive months by either the group policy or a combination of the group policy and the plan of long term disability benefits replaced by the group policy.

You will not be eligible to convert if any of the following apply to you:

• the group policy terminated or your employer's participation in the group policy terminated, even if your employment terminated coincident with such termination;
• you retire;
• you are eligible to receive long term disability benefits under the group policy, or you are in the waiting period for long term disability benefits under the group policy;
• you are eligible for, or insured for, similar benefits under another group plan or an individual policy;
• your insurance under the group policy terminated for any reason other than your termination of employment; or
• you apply for coverage more than 31 days after your date of termination.

Conversion Application Instructions

On the following page you will find a summary of the conversion benefits offered and a table of conversion rates. These rates vary by age.

To convert your long term disability benefits you must:

1. Complete the Application for Conversion of Long Term Disability Insurance. Be sure that you answer all questions.
2. Check to see that your employer has completed the employer information on the Application and that an authorized representative of the employer has signed the form. It is your responsibility to assure this information is completed and included on the Application before the Application is mailed. If the application is not complete, it will be returned to you.
3. Determine your quarterly premium using the worksheet and the table of conversion rates on the following page.
4. Sign and date the Application. Attach your first premium payment (made payable to AIG Life Insurance Company). Mail the Application and first payment to:

AIG Life Insurance Company
Attn: Client Services 3A
3600 Route 66
P.O. Box 1583
Neptune, NJ 07754-1583
Summary of Conversion Benefits

If the benefit percentage or maximum benefit shown below is greater than the comparable provision of the group policy from which conversion is being requested, the conversion policy that will be issued will be reduced so that the benefit percentage and/or maximum benefit of the conversion policy do not exceed the group policy amounts.

Conversion Benefits

<table>
<thead>
<tr>
<th>Benefit Percentage</th>
<th>60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Maximum Benefit</td>
<td>$2,000</td>
</tr>
<tr>
<td>Monthly Minimum Benefit</td>
<td>$50</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>180 days</td>
</tr>
<tr>
<td>Maximum Benefit Period</td>
<td>2 years RBD</td>
</tr>
</tbody>
</table>

In addition, the Plan contains the following benefit provisions:

- Regular occupation definition of disability
- Full family Social Security Other Income Offset provision with cost of living freeze
- Maternity as any other disability coverage
- Three Month Survivor Benefit
- Partial Disability feature

Table of Conversion Rates

The following are the premium rates that will apply each quarter and are based upon your age and each $100 of monthly benefit. To determine your monthly benefit, and the premium that applies, use the worksheet below together with the following rate table:

<table>
<thead>
<tr>
<th>Age</th>
<th>Table of Rates Per $100 of Monthly Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 35</td>
<td>$ .75</td>
</tr>
<tr>
<td>35 but less than 40</td>
<td>1.18</td>
</tr>
<tr>
<td>40 but less than 45</td>
<td>1.83</td>
</tr>
<tr>
<td>45 but less than 50</td>
<td>2.70</td>
</tr>
<tr>
<td>50 but less than 55</td>
<td>4.00</td>
</tr>
<tr>
<td>55 but less than 60</td>
<td>5.90</td>
</tr>
<tr>
<td>60 and older</td>
<td>10.49</td>
</tr>
</tbody>
</table>

Your initial rates will change effective with the first quarterly billing after the date you attain an age for which an increased rate would apply, based upon the above rate table, or the current rate table in effect.

Premium Worksheet

What is your age? ________________

1. Enter your annual salary on the date your employment ended, but do not enter more than $48,000: ________________.
2. Divide the figure in Step #1 by 12 and enter the answer: ____________________________.
3. Multiply the answer in Step #2 by 0.50 and enter the answer: ____________________________.
4. Divide the answer in Step #3 by 100 and enter the answer: ____________________________.
5. Using the rate table above, based upon your age, enter the rate: ____________________________.
6. Multiply the rate shown in Step #5 times the answer from Step #4 and enter the answer: ____________________________.

Your quarterly premium will be the amount in Step #6, until the rate changes because of your age change.
APPLICATION FOR CONVERSION OF LONG TERM DISABILITY INSURANCE

PLEASE TYPE OR PRINT ALL INFORMATION

To Be Completed By The Terminated Employee

1. Name: ____________________________________________________________________________________________________
   FIRST        MIDDLE        LAST

2. Home Address: ____________________________________________________________________________________________
   STREET
   ________________________________
   CITY         STATE        ZIP CODE

3. Sex   □ Male   □ Female
4. Social Security Number__________________________________________
5. Date of Birth____________

6. Name of Employer ____________________________________
7. Group LTD Policy Number ______________________

8. Are you eligible for or covered by any other Group Long Term Disability Insurance other than
   item #7 above?   □ Yes   □ No

I have been informed of my option to convert to a Group Long Term Disability Conversion Policy. I understand my
options, have completed the above Application for Conversion and I am enclosing the required premium payment

The statements above are true to the best of my knowledge and belief, and I agree that they shall form a part of the
contract of insurance requested.

Signature of Applicant _____________________________________________ Date ______________________

NOTE: Your employer MUST complete the information on the following page of this application. Once the Employer
information has been provided, you must send this application and the first premium payment to AIG Life Insurance
Company at the above address. This must be done within 31 days of the date your employment with the Employer ends.
AIG Life Insurance Company will not accept any application:

- that is received more than 31 days after the date your insurance ends; or
- if the first premium payment is not sent with the application.

Upon approval of this Application a Certificate of Insurance will be sent directly to you at the address provided
To Be Completed By The Employer

A) Employer (Firm Name and Division): ______________________________________________________________________________________

B) Address: ____________________________________________________________________________________________________________

STREET

______________________________________________________________________________________________

CITY STATE ZIP CODE

C) Group LTD Policy Number ________________ D) Maximum Benefit ________________ E) Benefit Amount ________%

F) Was the individual covered under your present Group LTD Plan, or under a combination of your present and prior Group LTD Plan, for at least 12 consecutive months? ☐ Yes ☐ No

G) Date employee terminated employment ____________________________

H) Employee’s basic monthly earnings at time of termination: Commissions: $ ______________ Salary: $ ______________

I) Employee’s occupation at time of termination ________________________________

J) Reason for employee termination ________________________________

K) Is the employee terminating employment as a result of retirement, leave of absence, or disability? ☐ Yes ☐ No

L) The date the conversion notice and application was given to the terminated employee ____________________________

Employer Representative Signature ____________________________________________ Date ______________

Title ____________________________________________ Phone Number ______________

NOTE: Terminated employee MUST complete the Application and return the form to AIG Life Insurance Company.
FOR RESIDENTS OF:

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurer 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.

ARKANSAS: 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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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 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.

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

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.

HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is 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 containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: A 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 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.

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

NEVADA: Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.
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 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 CIVIL FINES AND CRIMINAL 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.

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 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.

TENNESSEE: 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.

TEXAS: 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.

VIRGINIA: 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.

WASHINGTON: It is unlawful for any person, knowing it to be such, to: (a) present, or cause to be presented, a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under a contract of insurance; or (b) prepare, make, or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with intent that it be presented or used in support of such a claim.

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.

FOR RESIDENTS OF ALL OTHER STATES NOT LISTED ABOVE:

Warning: 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 facts materially thereto, commits a fraudulent insurance act, which may be a crime and subject such person to criminal and civil penalties.