

AIG Life Insurance Company

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

Member companies of American International Group, Inc.

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 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 AIG Employee Benefits Disability Claims Center at the address listed below.
 4. Notify AIG 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 CLAIM TO:

AIG Employee Benefits Disability Claims Center
P.O. 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.

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Employee's Statement

Mail To:
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 Farmington, CT 06034-0387

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 Code
Home Phone Number		Additional Phone Number		Social Security Number		Date of Birth	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Height	Weight		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		
Spouse's Name, if Applicable			Date of Birth	Is Spouse Working? <input type="checkbox"/> Yes If Yes, number of hours working <input type="checkbox"/> No			
Dependents you are responsible for (Check all that apply) <input type="checkbox"/> Children under 18 <input type="checkbox"/> Children 18-22 attending Elementary or Secondary school full time <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Workers' Compensation Carrier				Phone Number	
Do you expect to return to work? <input type="checkbox"/> Yes Date <input type="checkbox"/> 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 No	Receiving Yes No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date/ End Date
Salary Continuance/Sick Time		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
Social Security		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
Workers' Compensation		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
State Disability		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
Retirement or Pension (Employer, PERS, STRS, PERA, etc.) Please specify type		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
Other _____ (e.g. unemployment, union or no-fault benefits, etc.)		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>				
Were you hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Hospital				Date Admitted	Date Discharged	
Hospital Address			City		State	Zip Code	Phone Number
If disability is the result of pregnancy or childbirth: Expected Date of Delivery _____ Actual Date of Delivery _____							
Type of delivery: <input type="checkbox"/> Normal <input type="checkbox"/> C-Section		Post-Partum Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:					

Attending Physician's Name			Specialty			
Address		City		State	Zip Code	
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 Code	
LEVEL OF EDUCATION						
High School Graduate		<input type="checkbox"/> Yes <input type="checkbox"/> No		If No, last grade completed		
College Graduate		<input type="checkbox"/> Yes <input type="checkbox"/> No		Degree	Major	
Post Graduate		<input type="checkbox"/> Yes <input type="checkbox"/> No		Degree	Major	
Other Certificates/Technical Training						
Have you attended, or are you currently attending any trade schools or received other special training? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe						
Were you in the Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> 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						
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 AIG American General Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period AIG American General has approved my disability claim, I must report all details to AIG 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 AIG American General. AIG 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.						
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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CLAIMANT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, 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 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 AIG Employee Benefits Disability Claims Center, P.O. 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



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Employer's Statement

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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 _____ Policy Number _____

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 _____ Last day employee worked _____ First date absent _____ Reason employee stopped working _____
 Full-Time (_____) hours Part-Time (_____) hours

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

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

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

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 _____ Percentage of employee contribution to Group Pension _____% Effective date _____
Monthly amount: _____

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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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 <input type="checkbox"/> Right <input type="checkbox"/> Left

PREGNANCY *(if applicable)*

Expected date of delivery	Actual date of delivery	Type of delivery <input type="checkbox"/> Normal <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when?			
Is this condition related to the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you complete a Workers' Compensation claim form? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>(include surgery and medications, if any)</i>			

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

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

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:		Reach above shoulder <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently
Lift <i>(in pounds)</i> <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+		Climb <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently
Carry <i>(in pounds)</i> <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> 51-75 <input type="checkbox"/> 76+		Crawl <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently
Total hours	With positional change	Bend/stoop <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently
Sit 8 7 6 5 4 3 2 1	<i>(hrs)</i> _____	Drive cars, trucks, forklifts and/or other equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Stand 8 7 6 5 4 3 2 1	<i>(hrs)</i> _____	Be around moving equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No
Walk 8 7 6 5 4 3 2 1	<i>(hrs)</i> _____	Walk on uneven ground: <input type="checkbox"/> Yes <input type="checkbox"/> No
Alternately		
Sit/Stand 8 7 6 5 4 3 2 1	<i>(hrs)</i> _____	

CARDIAC (if applicable) <i>Functional Capacity (American Heart Association)</i>			
<input type="checkbox"/> Class 1 (No Limitation) <input type="checkbox"/> Class 2 (Slight Limitation) <input type="checkbox"/> Class 3 (Marked Limitation) <input type="checkbox"/> Class 4 (Complete Limitation)			
Blood Pressure (latest reading) ____ / ____ as of _____ Date Is patient in a cardiac rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> 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?			
<input type="checkbox"/> Class 1 – Patient is able to function under stress and engage in interpersonal relations (No Limitations) <input type="checkbox"/> Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (Slight Limitations) <input type="checkbox"/> Class 3 – Patient is able to engage only in limited stress situations and engage in only limited interpersonal relations (Moderate Limitations) <input type="checkbox"/> Class 4 – Patient is not able to engage in stress situations or engage in interpersonal relations (Marked Limitations) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
REHABILITATION/RETURN TO WORK When could trial employment begin?			
PATIENT'S JOB:		ANY OTHER WORK:	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Date _____		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Date _____	
<input type="checkbox"/> Unable to Determine: Follow-up in _____ weeks		<input type="checkbox"/> Unable to Determine: Follow-up in _____ weeks	
<input type="checkbox"/> Never		<input type="checkbox"/> Never	
Would job modification enable patient to work with impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain under Remarks.			
Is the patient a suitable candidate for: (check as many as apply)			
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Cardiac Rehabilitation Program	<input type="checkbox"/> Work Hardening Program	
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Cardiopulmonary Program	<input type="checkbox"/> Job Modification	
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Pain Management Program	<input type="checkbox"/> Other	
<input type="checkbox"/> Vocational Rehabilitation	<input type="checkbox"/> Psychological Counseling		
Was this discussed with the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you aware of any other disability income policies? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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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 _____