

# Terminal Illness Rider Claimant Statement

The Variable Annuity Life Insurance Company (VALIC)

Houston, Texas

To be completed by physician

## 1. PATIENT INFORMATION

Name of Patient: \_\_\_\_\_

Contract Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## 2. TREATMENT INFORMATION

Nature of patient's illness(es): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Life Expectancy (Select only one option):

One year or less

One year or greater

Prognosis of illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of physician who diagnosed illness: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Dates of diagnosis: \_\_\_\_\_

## 3. SIGNATURES

\_\_\_\_\_  
Signature of Dr/RN/Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Dr/RN/Director

\_\_\_\_\_  
Title and/or Professional Designation

**SIGNATURE MUST BE NOTARIZED:** \_\_\_\_\_

Notary Signature and Seal

Please send completed forms to:

VALIC Document Control

P.O. Box 15648

Amarillo, TX 79105-5648