corebridge financial

The Variable Annuity Life Insurance Company (VALIC)
The United States Life Insurance Company in the City of New York (USL)

Extended Care Rider Claimant Statement

To be completed by physician

1. PATIENT INFORMATION

Name of Patient: _____

Account Number: _____ Social Security Number: _____

2. PHYSICIAN AND TREATMENT INFORMATION

Name of treatment facility: _____

Type of facility: _____

Address of facility: _____ Phone: (_____) _____

City: _____

State: _____ ZIP: _____

Nature of treatment prescribed by physician (diagnosis): _____

_____

_____

_____

Medical records kept daily? _____

Medication given daily (please list): _____

_____

Name of physician who prescribed treatment: _____

Address: _____ Phone Number: (_____) _____

City: _____

State: _____ ZIP: _____

Dates of confinement to facility: From: _____ To: _____

3. SIGNATURES

_____ _____

Signature of Dr/RN/Director Date

_____

Title and/or Professional Designation

SIGNATURE MUST BE NOTARIZED: _____

Notary Signature and Seal

Please send completed forms to:

Retirement Services Center
P.O. Box 15648
Amarillo, TX 79105-5648