Extended Care Rider Claimant Statement

The Variable Annuity Life Insurance Company (VALIC)
Houston, Texas

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:

VALIC Document Control
P.O. Box 15648
Amarillo, TX 79105-5648