RESET

American General Life Insurance Company (AGL)
The United States Life Insurance Company in the City of New York (USL)

Address mail to:
Annuity Service Center

Regular Mail
PO Box 871
Amarillo TX 79105-0871

Overnight Mail
1050 N Western St
Amarillo TX 79106-7011

Phone: 800-424-4990
Fax: 806-342-1703
Website: corebridgefinancial.com
Email: annuityservice@corebridgefinancial.com

Authorization for Release of Records and Information

1. Please print or type.
2. If you are authorizing information to be released to anyone other than your attorney, please fill out Page 1 only.
3. If you are authorizing information to be released to your attorney, please fill out Page 2 only.

1 Account Information

Account Number _____ Owner's SSN _____

Owner's Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Joint Owner's Last Name _____ First Name _____ MI _____

2 Authorization To Release Records and Information

I/We _____, do hereby authorize the following person(s):
Owner / Annuitant Name(s)

_____ _____
Name of Authorized Person — Relationship To Account Owner / Annuitant

_____ _____
Name of Authorized Person — Relationship To Account Owner / Annuitant

to receive from American General Life Insurance Company or The United States Life Insurance Company in the City of New York (the "Company") and its subsidiaries any and all information and documents pertaining to my Company account number(s) _____on my behalf.

This Authorization shall remain in effect for **either:** Two (2) years from the date of my signature ***or*** if I am deemed incapacitated and/or incompetent by a Court of Law, whichever is sooner. I understand that if I wish to cancel this Authorization, then I, or my Court-appointed Guardian or Conservator, will need to submit a revocation request of this Authorization for Release of Records in writing to the Company.

I/We _____, further agree to indemnify and hold harmless the Company and its subsidiaries, affiliates, companies, representatives and parent companies, of and from all and any manner of actions that may occur as a result of disclosing information regarding my account to any and all of the person(s) I have named on this Authorization for Release of Records.

A photocopy of this Designation may serve in place of an original. **This form is invalid unless signed and dated by the Account Owner(s).**

3 Signature(s)

Date _____ _____
Authorization Expires Two Years From This Date — Signature of Account Owner

Date _____ _____
Authorization Expires Two Years From This Date — Signature of Joint Account Owner *(If applicable)*

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Designation of Attorney

1. Please print or type.
2. If you are authorizing information to be released to anyone other than your attorney, please fill out Page 1 only.
3. If you are authorizing information to be released to your attorney, please fill out Page 2 only.

1 Account Information

Account Number _____ Owner's SSN _____

Owner's Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

2 Attorney Information

I/We _____ have retained the Law Office(s) of:
Name of Account Owner(s)

_____ and his/her/their associates to represent me.
Name of Law Firm or Attorney

My Attorney's information is:
Name _____
Street Address _____
City, State and Zip _____
Telephone Number _____

This Designation of Attorney shall serve as an Authorization for the Company and its subsidiaries to release any and all information and documents pertaining to my Company account number(s) _____ to my Attorney and his/her/their associates and representatives upon his/her/their request.

This Authorization shall remain in effect for **either:** Two (2) years from the date of my signature or if I am deemed incapacitated and/or incompetent by a Court of Law, whichever is sooner. I understand that if I wish to cancel this Authorization, then I, or my Court-appointed Guardian or Conservator, will need to submit a revocation request of this Authorization for Release of Records in writing to the Company.

I/We _____, further agree to release, indemnify and hold
Name of Account Owner(s)
harmless the Company and its subsidiaries, affiliates, companies, representatives and parent companies, of and from all and any manner of actions that may occur as a result of disclosing information pursuant to this designation of attorney to

_____ and his/her/their associates and representatives.
Name of Attorney or Firm

A photocopy of this Designation may serve in place of an original. **This form is invalid unless signed and dated by the Account Owner(s).**

3 Signature(s)

Date _____
Authorization Expires Two Years From This Date

_____
Signature of Account Owner

Date _____
Authorization Expires Two Years From This Date

_____
Signature of Joint Account Owner *(If applicable)*