

New Mexico Notice of Information Practices

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019

To issue, renew, reinstate, exchange or change benefits on an insurance policy, or to process a claim for benefits, we may need to obtain information about you and any other persons applying for insurance or covered under the claim. Some of that information may be confidential abuse information that will come from you and/or from other sources.

Confidential Abuse Information is information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse, the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse, or a person with whom an applicant or insured is known to have a direct, close personal, family, or abuse-related counseling relationship.

Any confidential abuse information collected by a company in American General's life insurance division:

Cannot be used to deny, refuse to issue, renew, reissue, cancel or terminate a policy, or to restrict or exclude coverage or policy benefits, or to charge a higher premium for a policy.

Can, in certain circumstances*, be disclosed to third parties without your specific authorization, EXCEPT when otherwise requested by a 'protected person.'

*An insurer, any person employed by or contracting with an insurer, or any insurance support organization may disclose confidential information:

- to a victim of domestic abuse or an individual specifically designated in writing by the victim;
- to a health care provider for the direct provision of health care services;
- to a licensed physician identified and designated by the victim of domestic abuse;
- pursuant to an order of the Superintendent or a court of competent jurisdiction, or as otherwise required by law;
- when necessary for a valid business purpose, as specified in NMSA 59A-16B-4A(3)(e);
- to an attorney who needs the information to effectively represent the insurer, and who will exercise due diligence to protect the information;
- to the policyowner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status;
- to any other entities deemed appropriate by the Superintendent;
- to prepare its [an insurance support organization's] report to the insurer, but may not be disclosed to other persons without the written consent of the protected person except as otherwise permitted by NMSA 59A-16B-4.

An insurer, any person employed by or contracting with an insurer, or any insurance support organization shall not request or make use of confidential information, however obtained, except:

- for the limited purpose of complying with legal obligations;
- when verifying a person's claim to be a victim of domestic abuse or to be suffering from an abuse-related medical condition; or
- when cooperating with a victim of domestic abuse seeking protection from abuse or facilitating treatment of an abuse-related medical condition.

If you have been a victim of domestic abuse, have notified this insurance company that you are or have been a victim of domestic abuse, and you are a present or proposed policyowner, present applicant, present or proposed principal insured, or covered subject under a policy, or you are a present claimant for insurance benefits, you qualify as a 'protected person.'



As a protected person, you have a right to:

- (1) Authorize the release of any domestic abuse information collected about you, except information that relates to a claim or civil or criminal proceeding.
- (2) Access and receive within thirty (30) business days from the date a written request is received any confidential abuse information reasonably described by you and reasonably locatable and retrievable by the insurer or insurance support organization.
- (3) Request that any confidential abuse information about you in the insurer's files be corrected, amended or deleted within thirty (30) business days from the date of receipt of a written request.
- (4) Request participation in our location information confidentiality program. This program protects and limits access to location information, including the address and telephone number of the residence, place of employment, school or other location of a protected person.
- (5) Receive notification from the insurer within ten (10) days of its receipt of an order by the Superintendent of Insurance or a court to disclose the location information of a protected person.
- (6) Revoke in writing the authorization to release information effective ten (10) days after receipt by the insurer, understanding that a revocation of authorization may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

To exercise your rights as a 'protected person' complete the New Mexico Authorization to Obtain and Disclose Information and return it to the address of the company with whom you are applying for insurance as shown on the form.

This form is your written authorization to release confidential domestic abuse information to only specified persons or institutions.

For more information about the New Mexico Domestic Abuse Insurance Protection Act, contact the State of New Mexico, Corporation Commission, Department of Insurance, P.O. Box 1269, Santa Fe, NM 87504-1269.



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As a protected person, I hereby authorize the persons or organizations listed below to obtain and release confidential abuse information about me in order to evaluate my (our) application(s) for life or disability insurance or to process my (our) claim for benefits.

Confidential Abuse Information is information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse, the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse, or a person with whom an applicant or insured is known to have a direct, close personal, family, or abuse-related counseling relationship.

Such information may also include any and all information as to insurability; health history; complaints; diagnosis; type and dates of treatments; dates and results of special tests and prognosis; or facts of death.

<ul style="list-style-type: none">All American Life Insurance Companies*	<ul style="list-style-type: none">The Medical Information BureauAny medical or medically related facility, including hospitals, clinics or health care facilitiesAny physician or practitionerAny insurance company reinsurersInsurance support organizations
<ul style="list-style-type: none">Any agent authorized to represent the above named insurer(s)	<ul style="list-style-type: none">Any other insurance company
<ul style="list-style-type: none">Any medical, underwriting or claims personnel contracted with the above insurer(s)	<ul style="list-style-type: none">Any government agencyMy employer

This authorization is valid for:

- No longer than thirty (30) months from the date of this authorization and is applicable to my request for life, health or disability insurance.
- The term of coverage of the policy for a claim of health insurance benefits.
- The duration of the claim if the claim is not for health insurance benefits.

As a protected person, I am entitled to receive a copy of this form and to revoke its authority in writing, effective ten (10) days after the Company listed at the top of this form, with whom I have applied for insurance, receives it. I understand that revocation of this authorization may result in an application or claim being denied or may otherwise adversely affect a pending insurance action.

Protected Person's Signature

Applicant signed on (date) _____

Protected Person's name (printed) _____

Policy Number _____

Witness _____

