**American General**
Life Companies

# AG Exam-Free Term Upgrade℠ Program Transmittal Form

Policy Number ______________________ Applicant Name ____________________ DOB ____________
IMO/BGA/Agency Number ______________ IMO/BGA/Agency Name ______________________________
Agent Number ______________________ Agent Name ______________________ Date ____________

## QUALIFYING POLICY INFORMATION

Qualifying Policy Number: ______________________________
Rate Class: ______________________________
Face Amount: ______________________________
Policy Effective Date: ______________________________
Carrier's Name*: ______________________________

*If External Carrier – APPLICATION SUBMISSION MUST INCLUDE QUALIFYING POLICY'S SPECIFICATION PAGE AND OTHER CONTRACT PAGES TO PROVIDE THE FOLLOWING ITEMS: Carrier's name, insured's name, face amount, term period, underwriting class and policy effective date.

☐ New Application
☐ Underwriting Requirements
☐ Delivery Requirements
☐ Other ______________________________

## CONTACT INFORMATION FOR CASE FOLLOW UP

Name: ______________________________
Phone: ______________________________ ext: ____________
Fax: ______________________________
E-mail: ______________________________

## SPECIAL ISSUE INSTRUCTIONS

☐ Save Age ☐ Advance Date ______________ ☐ Date Current
☐ Draft Initial Premium ☐ This is a Companion Case ☐ Issue w/Companion Policy # ______________
☐ Applicant Name as it should appear on Policy ______________________________
☐ More than one application on same applicant ____________ (Indicate Additional or Alternate Application)
☐ If approved other than applied for, do not issue until we have accepted offer
☐ At approval, hold for issue instructions ☐ List Bill # ______________ Name: ______________
☐ Check Amount $ ______________ Name on Check: ______________________________

## OTHER SPECIAL INSTRUCTIONS

**Remember: http://estation.aglife.com is your source for policy and form information.**
By providing complete and accurate information, processing time can be expedited.

# Tips for Submitting a Complete and Compliant Replacement

If the application being submitted includes existing coverage, the following tips will assist in completing the replacement form and application.

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## Part A Application

### Existing Coverage Question

- Answer 'yes' or 'no' to the Existing Coverage question. If answer is 'yes':
  - Enter the Existing Policy Number, or write 'Unknown' in the space provided
  - Enter the Name of the Existing Carrier
  - Enter the Face Amount of the existing coverage

### Replacement Question

- Answer 'yes' or 'no' to the Replacement question.
  - If the existing coverage is 'Pending', the Replacement question should be answered 'no', unless the pending policy is under a binding or conditional receipt or is within an unconditional receipt refund period, even if the pending policy will not be put in force.
  - If the replacement question is answered 'yes', then a Replacement Notice is required. **However, in states that require notice form AGLC0188, the form should be completed if the Existing Coverage question is answered 'yes', even if not replacing.**

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## Agent's Report

- Answer 'yes' or 'no' to the Existing Coverage question.
- Answer 'yes' or 'no' to the Replacement question
- Both of these questions on the Agent's Report should match what the applicant indicated on the Part A.
- Complete all fields, including license number, agent address, agent phone number, etc.

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## Replacement Notice

- Verify that you have the correct Replacement Notice for the state in which the application is signed.
- Answer all replacement and financing questions; do not leave any fields blank.
- If the existing policy number is not known, applicant should write 'Unknown' in the space provided.
- Answer the **Reason for Replacement** section, if applicable.
- If the Notice has a Sales Material section, (1) complete it and (2) submit any individualized sales materials, including illustrations. If no sales materials were used, write 'None' in the space provided.
- Be sure the applicant signs and dates the form. **The Replacement Notice must be dated on or before the date of the Part A.**
- Agent signature and date are required.

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**Reminders:**

- Group coverage being replaced does not require a Replacement Notice; however, the Existing Coverage Question and Replacement Question are all required to be completed on the Part A.
- If an existing internal cash value policy (WL, UL, VUL or ROP Term) has lapsed or was cancelled within the last 4 months, the application is processed as a replacement and all replacement requirements apply.

Note: DO NOT submit this instruction sheet with the application packet.

# American General
Life Companies

## Term Insurance Application
## Part A

☐ **American General Life Insurance Company, Houston, TX**
☐ **The United States Life Insurance Company in the City of New York, New York, NY**
☐ **American General Life Insurance Company of Delaware, Wilmington, DE**

*Subsidiaries of American International Group, Inc.*

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

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**1. Primary Proposed Insured**

Name ______________________ Social Security # ______________

Sex ☐ M ☐ F Birthplace* *(state, country)* ______________ Date of Birth ______________ Current Age ____

**Tobacco Use** Have you ever used any form of tobacco or nicotine products? ☐ yes ☐ no If yes, date of last use ______________

If yes, *type* and *quantity* of tobacco or nicotine products used ______________

Driver's License ☐ yes ☐ no Number ______________ License State ______________

U.S. Citizen ☐ yes ☐ no If no, Date of Entry ______________ Visa Type ______________ Exp. Date ______________

Address ______________ City, State ______________ ZIP ______________

Home Phone ( ) ______________ Work Phone ( ) ______________ Email ______________

Employer ______________ Occupation ______________ Length of Employment ______________

Employer Address ______________ City, State ______________ ZIP ______________

Duties ______________

Personal Earned Income $ ______________ Household Income $ ______________ Net Worth $ ______________

If Primary Proposed Insured is a child or is age 18 or over and not self-supporting, what amount of insurance is in force on any of the following: Spouse $ ______________ Father $ ______________ Mother $ ______________ Siblings $ ______________

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**2. Owner**

**A. Complete if the Primary Proposed Insured is not the Owner** *(If contingent Owner is required, use Remarks section.)*

Name ______________ Social Security or Tax ID # ______________ Date of Birth ______________

Address ______________ City, State ______________ ZIP ______________

Home Phone ( ) ______________ Relationship to Primary Proposed Insured ______________

Email ______________

**B. Complete if Owner is a trust** (*If trustee is premium payor also complete section 8 D.)*

Exact Name of Trust ______________ Trust Tax ID # ______________

Address ______________ City, State ______________ ZIP ______________

Email ______________

Current Trustee(s) ______________ Date of Trust ______________

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**3. Plan of Insurance**

Product Name ______________ Amount Applied For $ ______________

Premium Class Quoted ______________ Reason for Insurance ______________

**Riders/Benefits**

☐ Child Rider Amount $ ______________ **(Complete Child Rider Attachment)** or ☐ No current children

☐ Waiver of Premium ☐ Accidental Death Benefit Amount $ ______________

☐ Disability Income Rider *(Complete the following if DI Rider is requested)*

Number of Units *(1 unit = $100):* ______________ Occupational Class *(Please check):* ☐ 1 ☐ 2

☐ Other Riders/Benefits #1 ______________ Amount/Unit(s) ______________

☐ Other Riders/Benefits #2 ______________ Amount/Unit(s) ______________

**for identification purposes only*

**4. Primary Beneficiary**

Name ______________________ Relationship ______________ Share ______%

Name ______________________ Relationship ______________ Share ______%

Name ______________________ Relationship ______________ Share ______%

**5. Contingent Beneficiary**

Name ______________________ Relationship ______________ Share ______%

Name ______________________ Relationship ______________ Share ______%

Name ______________________ Relationship ______________ Share ______%

**6. Trust Information (if Beneficiary)** Exact Name of Trust ______________________

Trust Tax ID # ______________ Current Trustee(s) ______________________ Date of Trust ____________

**7. Business Insurance Details** *(Complete only if applying for business coverage.)*

Does the Primary Proposed Insured have an ownership interest in the business? ☐ yes ☐ no

If yes, what is the percentage of ownership for the Primary Proposed Insured? __________%

Net Profit of Business $ ______________ Fair Market Value of Business $ ______________

If buy-sell, stock redemption, or key person insurance, will all partners or key people be covered? ☐ yes ☐ no

Describe any special circumstances. ______________________

**8. Premium Payment** ☐ Modal $______________

**A. Frequency of modal premium:** ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly *(Bank Draft only)*

**B. Method:** ☐ Direct Billing ☐ Bank Draft (*Complete Bank Draft Authorization.)* ☐ List Bill: Number ______________

☐ Credit Card - Initial Premium Only *(Complete Credit Card Authorization.)*

☐ Other *(Please explain.)* ______________________

**C. Amount submitted with application $** ______________________

**D. Premium Payor** *(Complete if other than Owner.)* Relationship to Primary Proposed Insured ______________

Name ______________________

Social Security or Tax ID # ______________________

Address ______________ City, State ______________ ZIP ____________

**9. Health and Age Questions** *(Regarding the Primary Proposed Insured, if the correct answer to either question below is "yes" or any question is answered falsely or left blank, coverage is not available under the Limited Temporary Life Insurance Agreement ("LTLIA") and it is void, and any payment submitted will be refunded. Read the LTLIA for additional terms and conditions of coverage.)*

**A.** Has the Primary Proposed Insured ever had a heart attack, stroke, cancer, diabetes, or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? ☐ yes ☐ no

**B.** Is the Primary Proposed Insured age 71 or above? ☐ yes ☐ no

**10. Existing Coverage**

**A. Life and Annuity Coverage**

**Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies? ☐ yes ☐ no**

*(If yes, complete the following regarding such annuities or life insurance policies.)*

**Type: i** = individual, **b**= business, **g**=group, **p**=pending life insurance or annuity

| Policy Number | Insurance Company | Type(s) *(see above)* | Year of Issue | Face Amount | Replace* |
|---|---|---|---|---|---|
| | | | | | ☐ yes ☐ no |
| | | | | | ☐ yes ☐ no |
| | | | | | ☐ yes ☐ no |
| | | | | | ☐ yes ☐ no |

***Replace** means that the insurance being applied for may replace, change or use any monetary value of any existing or pending life insurance policy or annuity. If replacement may be involved, complete and submit replacement-related forms. Please note: certain states require completion of replacement related forms even when other life insurance or annuities are not being replaced by the policy being applied for.

**10. Existing Coverage *(continued)***

**B. Disability Coverage *(Complete only if Disability Income Rider coverage requested.)***

**Does the Primary Proposed Insured have any existing or pending Disability insurance policies?** ☐ **yes** ☐ **no**

*(If yes, complete the following regarding existing or pending disability insurance)*

| Insurance Company | Benefit Amount | Benefit Period | Elimination Period | Year Issued |
|---|---|---|---|---|
| | | | | |
| | | | | |

**11. Background Information** *(Complete questions A through F. If yes answer applies to the Primary Proposed Insured, provide details specified after each question.)*

**A.** Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? ☐ yes ☐ no

*(If yes, list country, date, length of stay and purpose.)* ____________________

**B.** In the past five years, has the Primary Proposed Insured participated in, or does he or she intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; extreme sports or other hazardous activities? ☐ yes ☐ no

*(If yes, circle or list the applicable activities and complete the Aviation and/or Avocation Questionnaire.)* ____________________

**C.** Has the Primary Proposed Insured:

1) During the past 90 days submitted an application for life insurance to any company or begun the process of filling out an application? ☐ yes ☐ no

*(If yes, list company name, amount applied for, purpose of insurance and if application will be placed.)* ____________________

2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal? ☐ yes ☐ no

*(If yes, list date and reason.)* ____________________

**D.** Has the Primary Proposed Insured ever filed for bankruptcy? ☐ yes ☐ no

*(If yes, list chapter filed, date, reason and discharge date.)* ____________________

**E.** In the past five years, has the Primary Proposed Insured been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? ☐ yes ☐ no

*(If yes, list date, state, license no. and specific violation.)* ____________________

**F.** Has the Primary Proposed Insured ever been convicted of or pled guilty or no contest to a criminal offense or currently have any felony or misdemeanor charge pending? ☐ yes ☐ no

*(If yes, list date, state and charge.)* ____________________

## REMARKS

**12. Details and Explanations** ____________________

**American General Life Insurance Company, Houston, TX** **American General Life Insurance Company of Delaware, Wilmington, DE**
**The United States Life Insurance Company in the City of New York, New York, NY**

The above listed life insurance company ("Company") as selected on page one of this application is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

## Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured and Owner signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of the Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Limited Temporary Life Insurance Agreement ("LTLIA") – If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy and only if the following four conditions are met: (1) the full first modal premium is submitted with this application and paid; and (2) only "no" answers have been truthfully given to the Health and Age Questions in section 9; and (3) Part A and Part B of the application must be completed, signed and dated; and (4) all medical exam requirements must be satisfied. I understand and agree that such insurance is not available with any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

I give my consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me, my spouse or my minor children. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine: (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931.

This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. ☐ Check if you wish to be interviewed.

**IRS Certification:** Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

**Primary Proposed Insured/Owner Signature**

Signed at (city, state) ______________________ On (date) ______________

Primary Proposed Insured **X**______________________________

*(If under age 15, signature of parent or guardian)*

Owner *(If other than Primary Proposed Insured)* **X** ______________________

**Agent Signature**

I certify that the information supplied by the Primary Proposed Insured and Owner has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* ______________________ Writing Agent # ______________

Writing Agent Signature **X** ______________________ Countersigned ______________________

*(Licensed resident agent if state required)*

## Agent's Report

**1. Statements**

**A.** Number of years you have known the Primary Proposed Insured: ____________________

**B.** Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies? ☐ yes ☐ no
If yes, do you have any information that indicates that the Primary Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity with any company in connection with the purchase of insurance? ☐ yes ☐ no

*(If yes, please provide details in the Remarks section below and attach all replacement-related forms. Certain states require completion of replacement-related forms even when other life insurance or annuities are not being replaced by the policy being applied for.)*

**C.** Are you aware of any other information that would adversely affect the Primary Proposed Insured's eligibility, acceptability, or insurability? *(If yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.)* ☐ yes ☐ no

**D.** Did you provide the Owner with a Limited Temporary Life Insurance Agreement? ☐ yes ☐ no

**2. Remarks, Details and Explanations** *(Please include information on any collateral assignment, etc.)*

____________________

____________________

____________________

____________________

____________________

**3. Commission, Agent/Agency Information** *(Please list servicing agent first.)*

| Agent(s) to Receive Commission | Agency Number | Agent Number | Percent of Split |
|---|---|---|---|
| | | | % |
| | | | % |
| | | | % |
| | | | % |

Writing Agent Name *(Please print)* ____________________ Date ____________________

Writing Agent Signature **X** ____________________

State License # ____________________ Phone # ____________________

Email ____________________ Fax # ____________________

**For Home Office use**

Processing Center ____________________ Contact Person ____________________ Phone # ____________________

Servicing Agent (if other than writing agent) send policy/delivery requirements to ____________________

____________________

**American General**
Life Companies

# HIPAA Authorization - New Business

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") Authorization to Obtain and Disclose Information

______________________________ ____/____/____

**Name of Patient/Proposed Insured (Please Print)** **Date of Birth**

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company of Delaware, American General Life Insurance Company, American International Life Assurance Company of New York, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service company), (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American General Life Companies company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;

- determine my eligibility for benefits under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life Companies Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P. O. Box 4373, Houston, TX 77210-4373. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

| _______________________________ | _______________ |
| --- | --- |
| Signature of Proposed Insured or<br>Proposed Insured's Personal Representative | Date |

_______________________________

Description of Authority of Personal Representative
(if applicable)

## BANK DRAFT AUTHORIZATION

☐ **American General Life Insurance Company, Houston, TX**

☐ **The United States Life Insurance Company in the City of New York, New York, NY**

☐ **American General Life Insurance Company of Delaware, Wilmington, DE**

The company checked above ("Company") will withdraw the premiums from the specified account. "You", "your", "I", and "me" refer to the bank account Owner whose name appears below.

**How Automatic Bank Draft Works:** Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

**Automatic Bank Draft Agreement**

I hereby authorize and request the Company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the nonterminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason.

This must be dated and signed by the bank account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Financial Institution Name ______________________________

Financial Institution Address ____________________ City, State ____________________ ZIP __________

Routing Number |: | | | | | | | | | :|

Account Number | | | | | | | | | | | | | | | ||•

Type of Account: ☐ Checking ☐ Savings Credit Union: ☐ yes ☐ no

Name of Primary Proposed Insured ______________________________ Premium Amount $ __________

Frequency: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

Preferred Withdrawal Date (1st-28th) __________ ☐ **Please debit my account for all outstanding premiums due.**

Print Bank Account Owner(s) Name ______________________________

Signature(s) of Bank Account Owner(s) **X** ______________________________

**Please attach voided check or deposit slip.**

**Detach this page and leave it with the Proposed Insured(s)**

# NOTICES TO THE PROPOSED INSURED(S)

| **American General Life Insurance Company, Houston, TX** | **The United States Life Insurance Company in the City of New York, New York, NY** | **American General Life Insurance Company of Delaware, Wilmington, DE** |
|---|---|---|

You have applied for life insurance with one of the insurance companies identified above. "Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies LLC (AGLC), (a company providing services to affiliated life insurance companies that are members of American International Group, Inc.).

## FAIR CREDIT REPORTING ACT AND INVESTIGATIVE CONSUMER REPORTING AGENCIES ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), and your state's Investigative Consumer Reporting Agencies Act, notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that could include information about your character, general reputation, personal characteristics and mode of living, from one of the following consumer reporting agencies:

| Systematic Business Services, Inc.,<br>10101 Renner Boulevard,<br>Lenexa, KS 66219-9752, 800-444-7274 | Portamedic,<br>170 Mt. Airy Rd.,<br>Basking Ridge, NJ 07920, 800-444-3737 | Examination Management Services, Inc.,<br>3003 LBJ Freeway, Suite 200,<br>Dallas, TX 75234, 800-USA-EMSI |
|---|---|---|

If an investigative consumer report is ordered a copy will be provided to you within three (3) days after our receipt of the report.

## MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

## INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: American General Life Companies LLC, P.O. Box 1931, Houston, TX 77251-1931

## TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

## USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

*This form must be completed, signed and* ***left with the applicant.***

Limited Temporary Life Insurance Agreement (Agreement)

**THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. SUCH INSURANCE IS NOT AVAILABLE FOR ANY RIDERS OR ACCIDENT AND/OR HEALTH INSURANCE. PLEASE FOLLOW STEPS 1 - 4.**

1. **Check appropriate Company:**

☐ American General Life Insurance Company, Houston, TX
☐ The United States Life Insurance Company in the City of New York, New York, NY
☐ American General Life Insurance Company of Delaware,Wilmington, DE

In this Agreement, "Company" refers to the insurance company whose name is checked above, which is responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments. In this Agreement, "Policy" refers to the Policy or Certificate applied for in the application. In this Agreement, “Proposed Insured(s)” refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable.

2. **Complete the following:** *(please print)*

Primary Proposed Insured ____________________

Other Proposed Insured ____________________
*(applicable only for a joint life or survivorship policy)*

Owner *(if other than Primary Proposed Insured)* ____________________

Modal Premium Amount Received ____________________

Date of Policy Application ____________________

3. **Answer the following questions:**

| | Yes | No |
|---|---|---|
| a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? | ☐ | ☐ |
| b. Is any Proposed Insured age 71 or above? | ☐ | ☐ |

**STOP** If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.

**TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT**

**A. Eligibility for Coverage:** If the correct answer is YES to any of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

**B. When Coverage Will Begin:**
COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

***Coverage under this Agreement will not exist until all of the conditions listed above have been met.***

The first modal premium will be considered paid, if one of the following valid items is submitted with Part A of the application and that payment is honored: (i) a check in the amount of the first modal premium; (ii) a completed and signed Automatic Bank Draft Agreement; (iii) a completed and signed Credit Card Authorization form; (iv) a completed and signed salary savings authorization; (v) a completed and signed government allotment authorization; (vi) a completed and signed payroll deduction authorization. Temporary life insurance under this Agreement will not begin if any form of payment submitted is not honored. All premium payments must be made payable to the Company checked above. Do not leave payee blank or make payable to the agent. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued, or refunded if the Company declines the application or if the policy is not accepted by the Owner.

**C. When Coverage Will End:**

COVERAGE UNDER THIS AGREEMENT WILL **END** at 12:01 A.M. ON THE **EARLIEST** OF THE FOLLOWING DATES:

- The date the policy is delivered to the Owner or his/her agent and all amendments and delivery requirements have been completed;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Company;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it has declined or cancelled the application;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that the application will not be considered on a prepaid basis;
- The date the Company mails or otherwise provides a premium refund to the Owner or his/her agent; or
- 60 calendar days from the date coverage begins under this Agreement.

**D.** The Company will pay the death benefit amount described below to the beneficiary named in the application if:

- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under this Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under this Agreement have been met.

The total death benefit amount pursuant to this Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- $500,000 plus the amount of any premium paid for coverage in excess of $500,000; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

**4. Complete and sign this section:**

Any misrepresentation contained in this Agreement or the Receipt and relied on by the Company may be used to deny a claim or to void this Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of this Agreement or the Receipt.

*I, the Owner, have received and read this Agreement and the Receipt or they were read to me and agree to be bound by the terms and conditions stated herein.*

Signature of Owner ______________________________ Date ______________

Signature of Primary Proposed Insured ______________________________ Date ______________

Signature of Other Proposed Insured *(if applicable)* ______________________________ Date ______________

Writing Agent Name *(please print)* ______________________________ Writing Agent # __________

*This form to be completed, detached and **submitted with the signed application.***

## Limited Temporary Life Insurance Agreement Receipt

**1. Check appropriate Company:**

☐ American General Life Insurance Company, Houston, TX

☐ The United States Life Insurance Company in the City of New York, New York, NY

☐ American General Life Insurance Company of Delaware, Wilmington, DE

In this Receipt, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable. The "Agreement" refers to the Limited Temporary Life Insurance Agreement.

**2. Complete the following:** *(please print)*

Primary Proposed Insured ______________________________

Other Proposed Insured ______________________________
*(applicable only for a joint life or survivorship policy)*

Owner *(if other than Primary Proposed Insured)* ______________________________

Modal Premium Amount Received ______________________________

**3. Answer the following questions:**

| | Yes | No |
|---|---|---|
| a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? | ☐ | ☐ |
| b. Is any Proposed Insured age 71 or above? | ☐ | ☐ |

**STOP** If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under the Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under the Agreement.

The Company will pay the death benefit amount described below to the beneficiary named in the application if:

- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under the Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under the Agreement have been met.

The total death benefit amount pursuant to the Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- $500,000 plus the amount of any premium paid for coverage in excess of $500,000.

If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

**4. Complete and sign this section:**

Any misrepresentation contained in the Agreement or this Receipt and relied on by the Company may be used to deny a claim or to void the Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of the Agreement or this Receipt.

*I, the Owner, have received and read the Agreement and this Receipt or they were read to me and agree to be bound by the terms and conditions stated therein.*

Signature of Owner ______________________________ Date ____________

Signature of Primary Proposed Insured ______________________________ Date ____________

Signature of Other Proposed Insured *(if applicable)* ______________________________ Date ____________

Writing Agent Name *(please print)* ______________________________ Writing Agent # ____________

# American General
Life Companies

## Life Insurance Application Part B

☐ **American General Life Insurance Company, Houston, TX**
☐ **The United States Life Insurance Company in the City of New York, New York, NY**
☐ **American General Life Insurance Company of Delaware, Wilmington, DE**
*Subsidiaries of American International Group, Inc.*

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

### Personal Information

1. **Proposed Insured** *(Complete separate Part B for each Proposed Insured)*

Name ______________________ Date of Birth ____________ Social Security # ______________

### Medical History

*(Instructions: Please answer ALL medical history questions. Do not leave any questions blank.)*

2. **Physician Information**

Name, address and phone number of the Proposed Insured's personal physician(s). *(If no personal physician, provide name, address and phone number of doctor last seen.)*

Name ______________________________ Phone ( ) ______________

Address ____________________ City, State ____________________ ZIP ____________

Date, reason, findings and treatment at last visit ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

3. **Build**

**A.** Admitted Height and Weight __________ ft. __________ in. __________ lbs

*(Examiners: Also record measured height and weight on Exam page 1.)*

**B.** Has the Proposed Insured had any weight change in excess of 10 lbs. in the past year? ☐ yes ☐ no If yes, complete the following:

Loss ________ lbs. Gain __________ lbs. Reason ______________________________

4. **Family History**

| | Age if Living | Age at Death | Cause of Death | History of Heart Disease? | History of Cancer? |
|---|---|---|---|---|---|
| Father | ______ | ______ | ______________ | ☐ No ☐ Yes ________ Age of Onset | ☐ No ☐ Yes ________ Age of Onset Type ________ |
| Mother | ______ | ______ | ______________ | ☐ No ☐ Yes ________ Age of Onset | ☐ No ☐ Yes ________ Age of Onset Type ________ |
| Brother | ______ | ______ | ______________ | ☐ No ☐ Yes ________ Age of Onset | ☐ No ☐ Yes ________ Age of Onset Type ________ |
| Brother | ______ | ______ | ______________ | ☐ No ☐ Yes ________ Age of Onset | ☐ No ☐ Yes ________ Age of Onset Type ________ |
| Sister | ______ | ______ | ______________ | ☐ No ☐ Yes ________ Age of Onset | ☐ No ☐ Yes ________ Age of Onset Type ________ |
| Sister | ______ | ______ | ______________ | ☐ No ☐ Yes ________ Age of Onset | ☐ No ☐ Yes ________ Age of Onset Type ________ |

**5. Personal Health History**

**A.** Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:

1) heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? ☐ yes ☐ no

2) a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☐ no

3) cancer, tumors, masses, cysts or other such abnormalities? ☐ yes ☐ no

4) diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system? ☐ yes ☐ no

5) colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? ☐ yes ☐ no

6) a disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine? ☐ yes ☐ no

7) asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? ☐ yes ☐ no

8) seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including a mental or nervous disorder? ☐ yes ☐ no

9) arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? ☐ yes ☐ no

*(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details**________________________________________

**B.** Is the Proposed Insured currently taking any medication, treatment or therapy or under medical observation? ☐ yes ☐ no

*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details**________________________________________

**C.** Has the Proposed Insured in the past three years had but NOT sought treatment for:

1) fainting spells, nervous disorder, headaches, convulsions or paralysis? ☐ yes ☐ no

2) any pain or discomfort in the chest or shortness of breath? ☐ yes ☐ no

3) disorders of the stomach, intestines or rectum, or blood in the urine? ☐ yes ☐ no

*(If yes, list condition such as: date of first occurence; symptoms; and how treated.)*

**Details**________________________________________

**D.** Has the Proposed Insured ever:

1) sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? ☐ yes ☐ no

2) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? ☐ yes ☐ no

*(If yes answered to D1 or D2, please provide details below.)*

Type of drug(s)/alcohol product(s) ____________ Date last used ________

Name(s) of doctor/facility____________ Phone (     )________

Address __________ City, State __________ ZIP ________

Treatment Dates ____________________

Support group(s) ____________ Last date attended ________

Details of any drug or alcohol related arrests ____________________

**5. Personal Health History *(continued)***

**E.** Has the Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☐ no

*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details**________________________________________

**F.** Other than previously stated, in the past 10 years, has the Proposed Insured:

1) been hospitalized, consulted a health care provider or had any illness, injury or surgery? ☐ yes ☐ no

*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details**________________________________________

2) been advised to have any diagnostic test, hospitalization or treatment that was NOT completed? ☐ yes ☐ no

*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; recommended tests, medications or treatment.)*

**Details**________________________________________

3) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition? ☐ yes ☐ no

*(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details**________________________________________

**G.** Does the Proposed Insured have any symptoms or knowledge of any other condition that is NOT disclosed above? ☐ yes ☐ no

*(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)*

**Details**________________________________________

## Agreement and Signatures

I, the Proposed Insured signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of the Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

**Fraud**

Any person who, with intent to defraud or facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**SIGNATURE OF PROPOSED INSURED**

Signed at *(city, state)* ______________________ On *(date)* ______________

X ______________________________
Proposed Insured *(If under age 15, signature of parent or guardian)*

**SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE**

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part B application.

**If Agent recorded information**

______________________ ______________________ ______________
Writing Agent Name *(Please print)* Writing Agent # Date

X ______________________ X ______________________
Writing Agent Signature Countersigned *(Licensed resident agent if state required)*

**If Tele-interviewer recorded information**

______________________ ______________________ ______________
Name *(Please print)* Company Date

**If Paramedical Examiner/Medical Doctor recorded information**

Examiner's Address ______________________ **Paramed: Use company stamp below.**

Examiner's Phone # (    ) ______________________

Examiner's Name ______________________

Examiner's Signature

X ______________________ Date ______________

## Physical Measurements

**1. Proposed Insured**

**A.** Name ______________________________

**B.** Build: Measured Height *(in shoes)* ______ ft. __________ in. Weight *(clothed)* __________lbs *(Please weigh insured.)*

**C.** Are you currently taking Blood Pressure Medication(s)? ☐ yes ☐ no

Medication(s) ______________________________

______________________________

Blood Pressure *(Record all readings.)* If blood pressure exceeds 140/90, repeat reading at end of examination.*

| | 1st Reading | 2nd Reading | 3rd Reading | *Repeat Reading |
|---|---|---|---|---|
| Systolic BP | | | | |
| Diastolic 5th Phase BP | | | | |
| Pulse Rate | | | | |
| Irregularities Per Min. | | | | |

**D.** Did you weigh Proposed Insured? ☐ yes ☐ no

**E.** Have any of the following been completed in conjunction with this exam?
☐ Blood ☐ Urine ☐ EKG ☐ Stress Test ☐ Chest x-ray

**F.** Is appearance unhealthy or older than stated age? ☐ yes ☐ no

**G.** Do you have any pertinent information not disclosed previously? ☐ yes ☐ no

*(Details of yes answers to questions F and G)*

______________________________

______________________________

______________________________

______________________________

______________________________

**H.** Are you related to the Proposed Insured by blood or marriage or do you have any business or professional relationship with the Proposed Insured? *(If yes, explain.)* ☐ yes ☐ no

______________________________

______________________________

## Report By Examining Medical Doctor

**Instructions to doctor:**

To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1) Heart

a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? ______________________________ ☐ yes ☐ no

b. Is heart enlarged? *(If yes, describe.)* ______________________________ ☐ yes ☐ no

c. Is murmur present? *(If yes, complete 1d.)* ______________________________ ☐ yes ☐ no

d. Before exercise, murmur is:

☐ Constant Transmitted to where?______________________________

☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere

☐ Systolic *(Give details.)* ______________________________

☐ Diastolic Murmur grade: *(Please circle)* 1/6 2/6 3/6 4/6 5/6 6/6

After valsalva, murmur is:

☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

Your impression ______________________________

______________________________

______________________________

**Report by Examining Medical Doctor *(continued)***

2) Has this examination revealed any abnormality of the following: *(Provide details to yes answers below.)*

a) Eyes, ears, nose, mouth and throat? *(If vision or hearing is markedly impaired, indicate degree and correction.)* ☐ yes ☐ no

**Details**____________________

b) Endocrine system *(including thyroid)*? ☐ yes ☐ no

**Details**____________________

c) Nervous system *(including reflexes, gait, paralysis)*? ☐ yes ☐ no

**Details**____________________

d) Respiratory system? ☐ yes ☐ no

**Details**____________________

e) Abdomen *(including scars)*? ☐ yes ☐ no

**Details**____________________

f) Genito-urinary system? ☐ yes ☐ no

**Details**____________________

g) Skin *(including scars)*, lymph nodes, blood vessels *(including varicose veins)*? ☐ yes ☐ no

**Details**____________________

h) Musculoskeletal system *(including spine, joints, amputations, deformities)*? ☐ yes ☐ no

**Details**____________________

**Signature**

**Paramedical Examiner/Medical Doctor Signature**

I certify that this exam was conducted the ________ day of __________ , 20 _____, at _____ ☐ am ☐ pm

Location of Exam ____________________ **Paramed: Use company stamp below.**

Examiner's Address ____________________

Examiner's Phone # (     ) ____________________

Examiner's Name ____________________

Examiner's Signature **X** ____________________

*(Agent should inform Paramedical Examiner/Medical Doctor of proper location to send form upon completion.)*

**American General**
Life Companies

# Disclosure for Term Life Insurance Policies

**American General Life Insurance Company**
*A subsidiary of American International Group, Inc.*

The following disclosure information is required by the Department of Insurance.

You are applying for a term policy with level premiums guaranteed for a specified period. After the specified period, premiums increase annually. Like many term policies, this policy does not provide nonforfeiture benefits (such as cash surrender values) at any time. This means that if you fail to pay a premium within the grace period, this policy lapses without value.

You may wish to compare this policy against another term policy with identical coverage containing nonforfeiture benefits (such as cash surrender values) at certain durations. Premiums might be higher for this other kind of term policy than the policy you are applying for.

You should consider the value of having nonforfeiture benefits versus the level of premiums that you will pay.