Tips for Accelerated Application & Compliant Replacement Processing

Complete, detailed, legible information can improve the application to issue timing. Shown below are key data elements and forms that will help to ensure an in-good-order application and minimize app to issue turnaround time.

Coversheet/Transmittal – Please provide:

- Contact name, phone, and e-mail address
- Companion and/or Alternate/Additional policies, if applicable
- Special issue or other instructions

Part A – Please provide or complete in legible handwriting -- e.g., capital letters and no cursive handwriting:

- Correct state version of application received
- Name, address and date of birth (must be legible)
- Social Security number (insured and owner SSN needed, if different parties)
- Birthplace
- All tobacco use questions answered
- Driver's license number and state, if applicable; Questions must be answered if applicant is over 16 years of age
- All employer and employment information
- All income specified
- Citizenship information
- Owner information, if different than applicant
- Beneficiary information
- Entity Information / Trust ID for owner
- Plan name and term, if applicable
- Face amount for insured and any riders requested
- Premium frequency and method
- Bank draft and/or void check provided for monthly payment, if applicable
- Initial Premium Received – if yes, Limited Temporary Life Insurance (LTLIA) may be applicable; See Other Forms section below.
- All payor information including SSN, if payor different than applicant/owner
- All replacement information must be received
  - Existing coverage, (insuring) company name and face amount
  - NAIC replacement form for NAIC states is other coverage exists
  - Correct state required replacement form(s) received
  - Refer to the Replacement Section of this form for additional, more detailed information.
- All background information questions answered with complete details provided for any "Yes" answers
- Signatures of Insured & Owner (if owner is different than insured)
- City/State/Date of signing
- Agent's signature
- All pages of application and supplemental forms (see below for more info on commonly needed forms)

Other Forms – (varies by product, coverage requested and state) – Please provide or complete:

- Agent Report
  - Agent questions, agent/agency codes and agent signature are required
  - Answer 'yes' or 'no' to the inforce and/or pending coverage question (must match answer on Part A)
  - Answer 'yes' or 'no' to the coverage being replaced question (must match answer on Part A)
  - License number, agent phone number, email and fax number
- Paramedical Exam with lab slip or Part B, if required
  - Must be on the same state form as Part A; All questions answered with details provided for any 'Yes' answers
- Child Rider Supplement, if applying for Child coverage
- Variable Universal Life Insurance Supplemental App, if applying for a Variable Universal Life product
- Index Universal Life Supplement, if applying for an indexed universal life product

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- Limited Temporary Life Insurance (LTLIA) Agreement,
  - If eligible for LTLIA, collect initial premium and complete agreement; LTLIA is given to applicant and copy or duplicate original is returned to American General.
  - If not eligible for LTLIA, do NOT collect initial premium and do NOT complete LTLIA.
- Illustration or quotation, when applicable
  - Must match application information
- State applicable disclosure forms
- State required HIV forms
- HIPAA authorization with applicant signature

Replacement Section – Shown below are 3 critical areas of focus -

Existing Coverage Information

- Answer 'yes' or 'no' to the inforce or pending policies question. (A); If 'yes',
  - Provide Policy Number or write 'Unknown' in the Policy Number field (B)
  - Provide name of existing insurer in Company Name field (C)
  - Provide face amount of existing coverage in the Amount of Coverage field (D)
  - Provide insured's name if a multi person app is being taken (E)

Replacement Information

- Answer 'yes' or 'no' to coverage being replaced question (F)
  - If an application for other coverage is pending, the replacement question should be answered 'no', unless some sort of limited, temporary coverage related to that application exists, even if no policy is to be put inforce.
  - If the replacement question is answered 'yes', then a Replacement Notice is required. However, in states that require notice form AGLC0188, the form MUST be completed if the existing coverage question (A) is answered 'yes', even if not replacing.

1035 Information

- Answer 'yes' or 'no' to the 1035 Exchange question. (G)

Existing Coverage and Replacements

"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

A. Do any of the Proposed Insureds have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company? (A) ☐ **yes** ☐ **no**

B. If question 12A is answered "yes", please provide the following information:

No.	Policy Number	Year of Issue	Coverage (see below)	Benefit Period (if DI)	Type (see below)	Coverage Being Replaced? (F)	1035 Exchange? (G)
1	(B)					☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ (C)				Amount of Coverage $ _____ (D)		
	Proposed Insured Name: _____ (E)						

Notice Regarding Replacement

- Verify use of 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 or contract 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(s). **Notice Regarding Replacement must be dated on or before the date of the Part A.**
- Agent signature and date are required.

Reminders:

- Group coverage being replaced does not require a Notice Regarding Replacement; 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.

Individual Life Insurance Application
Single Insured – Part A
California Version

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

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.

1. Primary Proposed Insured

First Name _____ MI___ Last Name _____ Gender ☐ M ☐ F
SSN _____ Birthplace* *(US State, or country)* _____ DOB_____ Current Age____
Tobacco Use Has the Primary Proposed Insured ever used any form of tobacco or nicotine products? ☐ yes ☐ no
Type and *Quantity* Used_____ If yes, a current user? ☐ yes ☐ no If no, date of last use _____
Driver's License ☐ yes ☐ no License State _____ Number_____
If over age of 16 and no license, please explain._____
Address _____ City _____ State_____ ZIP_____
Primary Phone _____ Alternate Phone _____ Email _____
Employer _____ Occupation_____ Date of Employment (mm/dd/yy) _____
Job Duties _____ Average No. of hours worked per week _____
Actively at work? ☐ yes ☐ no Able to perform all job duties? ☐ yes ☐ no If either is no, explain _____
Personal Earned Income (Annual): $ _____ Household Income (Annual): $ _____ Net Worth $ _____
Personal Earned Income means monies received for work performed.
If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force and/or pending on:
Owner $ _____ Spouse $ _____ Father $ _____ Mother $ _____ Siblings $_____ Premium Payor $ _____
Citizenship U.S. Citizen or Permanent Resident Card holder ☐ yes ☐ no If no, answer the following:
Country of Citizenship _____ Date of Entry_____ Visa Type_____ (Copy of Visa Required)
Own property or have a mortgage in the U.S.? ☐ yes ☐ no Plan to remain in the U.S.? ☐ yes ☐ no

2. Owner - Complete if Primary Proposed Insured is not the Owner - *(If Owner is a business, charitable entity or trust, answer question 5 below.)*

First Name _____ MI___ Last Name _____ Gender ☐ M ☐ F
SSN _____ DOB _____ Relationship to Proposed Insured _____
Driver's License ☐ yes ☐ no License State _____ Number_____
U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship _____ Date of Entry_____
Visa Type _____ Exp. Date _____
Address _____ City _____ State_____ ZIP_____
Primary Phone _____ Email _____
(If contingent Owner is required, use question 12.)

3. Reason for Insurance - *(If Business, complete Financial Questionnaire)* _____

4. Beneficiary - *(If Beneficiary is a business, charitable entity or trust, answer question 5 below.)*

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1							☐ Primary ☐ Contingent
	Address:		Email:				
2							☐ Primary ☐ Contingent
	Address:		Email:				
3							☐ Primary ☐ Contingent
	Address:		Email:				

**for identification purposes only*

5. Entity Information - *Complete if Owner or Beneficiary is a business, charitable entity or trust. If applicable, complete the Certification of Trust.*

(Check the applicable boxes information applies to: ☐ Owner and/or ☐ Beneficiary. If also the Premium Payor, complete section 9E.)

Exact Name _____ Tax ID # _____

Address _____ City _____ State_____ ZIP_____

Current Trustee Name _____ Date of Trust _____

Corporate Officer Name_____ Title _____

Email Address of applicable Trustee or Corporate Signer_____

Relationship to Proposed Insured _____ Type of Entity (SCorp, CCorp , DBA, etc.) _____

6. Product - *Signed Illustration/Quotation is required for all UL & VUL products.*

Plan Name (Complete appropriate supplemental application if applicable. For Index UL, complete the Index UL Supplemental Application.)

_____

Term Duration**_____ Premium Class Quoted _____

Amount Applied For: Base Coverage $_____ Supplemental Coverage** $_____

Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation I Automatic Premium Loan**: ☐ yes ☐ no

7. Death Benefit Options - *(For UL & VUL only)* ☐ Level ☐ Increasing

8. Riders/Benefits - *Refer to Rider Reference Page for riders and benefits available per product.*

☐ Accidental Death Benefit $ _____
☐ Child Rider[1] $_____
☐ No current children
☐ Chronic Illness Rider (AAS)[2]
☐ Lifestyle Income[3]
Withdrawal Benefit Basis % _____
☐ Terminal Illness
☐ Waiver of Monthly Deduction
☐ Waiver of Monthly Guarantee Premium
☐ Waiver of Premium
☐ Other #1 _____
Amount/Unit(s) _____
☐ Other #2 _____
Amount/Unit(s) _____
☐ Other #3 _____
Amount/Unit(s) _____
☐ Other #4 _____
Amount/Unit(s) _____

1 - Complete Child Rider Supplement
2 - Complete Chronic Illness Supplement
3 - Chronic Illness Rider (AAS) required with Lifestyle Income when AAS is approved. This requirement varies by product. Complete Chronic Illness Supplement, if applicable.

9. Premium Payment ☐ Modal $ _____ ☐ Single $_____ ☐ Additional/Lump Sum $ _____

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. Special Dating *(not available for VUL products):* Save Age ..... ☐ yes ☐ no

E. Premium Payor *(Complete if Payor is other than Owner or if Owner is Trustee.)*

First Name _____ MI ___ Last Name _____ Gender ☐ M ☐ F

SSN or Tax ID # _____ Relationship to Primary Proposed Insured _____

Driver's License ☐ yes ☐ no License State _____ Number _____ DOB_____

U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship _____ Date of Entry_____

Visa Type _____ Exp. Date _____

Address _____ City _____ State_____ ZIP_____

If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form.

10. Existing Coverage and Replacements

"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

A. Does the Primary Proposed Insured have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?..... ☐ **yes** ☐ **no**

***Complete only if applicable*

B. If question 10A is answered "yes", please provide the following information:

No.	Policy Number	Year of Issue	Coverage (see below)	Benefit Period (if DI)	Type (see below)	Coverage Being Replaced?	1035 Exchange?
1						☐Y ☐N	☐Y ☐N
	Company Name: _____				Amount of Coverage $ _____		
2						☐Y ☐N	☐Y ☐N
	Company Name: _____				Amount of Coverage $ _____		
3						☐Y ☐N	☐Y ☐N
	Company Name: _____				Amount of Coverage $ _____		

Coverage: LI=Life, H=Health, A=Annuity, LT=LTC, DI= Disability Income **Type:** i=individual, b=business, g=group, p=pending

11. Background Information - *Provide details specified for all "Yes" answers or complete applicable questionnaires.*

A. Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? *(If yes, list country(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire)* ..... ☐ yes ☐ no

_____

B. In the past five years, has the Primary Proposed Insured flown as a pilot, student pilot or crew member of any aircraft, or have any intention to do so in the next two years? *(If yes, complete the Aviation Questionnaire)* .. ☐ yes ☐ no

C. In the past five years, has the Primary Proposed Insured engaged in motor sports events or racing (auto, truck, motorcycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning,) or have any intention to do so in the next two years? *(If yes, complete the Avocation Questionnaire)* .... ☐ yes ☐ no

D. Has the Primary Proposed Insured ever had an application for insurance modified, rated, declined, postponed or withdrawn? *(If yes, list type of coverage, date and reason)* ..... ☐ yes ☐ no

_____

E. Has the Primary Proposed Insured ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? (*If filed, list chapter filed, date, reason, and discharge date)* ..... ☐ yes ☐ no

_____

F. In the past five years, has the Primary Proposed Insured been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs? *(If yes, list date, state, license #, and specific violation)* ... ☐ yes ☐ no

_____

G. Has the Primary Proposed Insured ever been convicted of, or is currently charged with, a felony or misdemeanor, or currently incarcerated or on parole or probation? *(If yes, list date, county, state, charge, and current status)* .... ☐ yes ☐ no

_____

H. Is the Primary Proposed Insured an active duty service member of the U.S. Armed Forces? *(If yes, provide Pay Grade, Rank and any known foreign assignments, and complete any required Military Sales Disclosure)* ..... ☐ yes ☐ no

_____

I. Is there an intention that any party, other than the listed Owner or Beneficiary, will obtain any right, title, or interest in any policy issued on the life of the Primary Proposed Insured as a result of this application? ..... ☐ yes ☐ no

J. Does the Owner or Primary Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ..... ☐ yes ☐ no

K. Is the Owner, Primary Proposed Insured, or any person or entity, being paid (cash, services, or any other form of payment) as an incentive to enter into this transaction? *(If yes, describe the incentive)* ..... ☐ yes ☐ no

_____

12. The space below may also be used to elaborate on answers to any questions on this application.

_____

_____

_____

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured (and any Owner signing below) acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. 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 ("LTLIA"), 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) that may be issued by the Company unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; (2) the full first modal premium for the issued policy has been paid; and (3) to the best of my knowledge and belief there has been no change in the health of any Proposed Insured(s) that would change the answer to any question 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 be 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.

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 the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the conditions set forth in the LTLIA are met. I understand and agree that such temporary insurance is not available as to 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 of or have been read the Notices to the Proposed Insured(s).

I authorize any medical professional; any hospital, clinic or other health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; the Medical Information Bureau (MIB); or any accountant, attorney, financial advisor, court, or government records custodian that has any records or knowledge of me or my physical or mental health or insurability, or that of any minor child for whom application for insurance is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its 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 concerning me, or any minor child for whom application for insurance is being made. Other information may include, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this application. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; 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 the Company, its affiliated insurers, and its affiliated service companies to obtain an investigative consumer report on me. I understand that I may: (1) request to be interviewed for the report; and (2) upon written request, receive a copy of such report.

☐ Check if you wish to be interviewed.

IRS Certification: Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: _____), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person*, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: _____). **Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you can complete a Form W-9 and you are a U.S. citizen or U.S. resident alien, FATCA reporting may not apply to you. Please consult your own tax advisors.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Owner Signature

X

Owner Title _____
(If Corporate Officer or Trustee)

Owner signed at (city, state) _____

Owner signed on (date)_____

Primary Proposed Insured Signature (if other than Owner)

X

(If under age 16, signature of parent or guardian)

Agent(s) Signature(s)

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* _____

Writing Agent # _____

Writing Agent Signature **X** _____

Other Parent or Guardian Signature

X

(If under age 16 and coverage exceeds $150,000, signature of both parents required)

AIG

Agent's Report

Policy # (if known): _____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** 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.

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #

1. Is more than one application being submitted at this time or pending for the Proposed Insured(s), family members, or business associates? *(If Yes, provide details in the Remarks section below.)* ☐ yes ☐ no

2. Does any Proposed Insured(s) have any existing or pending annuities or life insurance policies? *(If yes, 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 - please attach such forms.)* ☐ yes ☐ no

3. If yes to question 2, do you have any information the Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for? *(If yes, please provide details in the Remarks section below and attach replacement-related forms.)* ☐ yes ☐ no

4. Are you aware of any other information that would adversely affect the eligibility, acceptability, or insurability of any Proposed Insured(s)? ☐ yes ☐ no

5a. Will a medical exam be conducted? ☐ yes ☐ no

5b. If no, did you personally see all Proposed Insured(s) when the application was written? *(If no, provide explanation in the Remarks section below.)* ☐ yes ☐ no

6. If accidental death is applied for, what is the total amount of accident coverage inforce and applied for? _____

7. Is applicant applying for an applicable QoL Advantage option available on select QoL Products? *(If yes, complete QoL Advantage Form)* ☐ yes ☐ no

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

9. Remarks, Details, and Explanations *(Please include information on any policy collateral assignments, etc.)*

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9. Remarks, Details, and Explanations *(continued)*

10. Agent/Agency Information *(Please list servicing agent first)*

Note: The commission designation cannot be 100% for an agent other than the writing agent. Total allocations must equal 100%. Use whole percentages only; 0% is not a valid entry.

	Agent(s) Splitting Application	Agency Number	Local Office Code	Agent Number	Percentage of Split
Servicing Agent:					%
					%
					%
					%
					%

11. Agent Agreement and Signature

I certify that the above information is true and complete to the best of my knowledge and belief. If I become aware of information contrary to any of the answers contained in the life insurance application to which this Agent's Report relates or contained in any supplemental applications, questionnaires, or other forms, I will notify the company of such information.

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

Writing Agent Signature **X** _____

State License # _____ Phone # _____

Email _____ Fax # _____

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

_____ ___/___/___

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

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies 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 ("Providers") to provide the information outlined above:

- any physician, nurse or medical practitioner or practitioner group;
- 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 of the Companies (as defined above) 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;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect 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 Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the 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 understand that the Recipients requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in an efficient manner, including electronic interchange through a Health Information Exchange or directly through my Providers' electronic health record system.

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 9000, Amarillo, TX 79105-9000. 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 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 Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X

Signed on (date) _____

Signor name (printed) _____

Relationship _____

Description of Authority of Personal Representative (if applicable) _____

_____

Control Number/Policy Number _____

_____

Bank Draft Authorization

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water Street, New York, NY 10038

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** 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.

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.

Policy Number, if available	Name of Insured Applicant	Policy Number, if available	Name of Insured Applicant

PAYMENT OPTIONS: Please select ONLY one payment option:

☐ Draft Initial Premium and Draft Subsequent Premiums

Initial Premium: $_____.___ ☐ At Issue ☐ At Submit (Not available for all products or Employer Sponsored Plans)

- Initial premium at issue will be drafted at the time each policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.
- Initial premium will be drafted at Submit for those policies that qualify for this option. Additional initial premium due will be drafted at the time the policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.

Subsequent Premiums, if different: $_____.___

☐ Draft Only Subsequent Premiums

Check/Complete one of the following for Initial Premium payment:

☐ Check submitted with application in the amount of $_____.___.
☐ Check submitted on delivery.

DRAFT DETAILS: Please provide the requested details.

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

If a preferred withdrawal date is chosen and draft at issue is selected, we will draft subsequent premiums on this date.

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

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Type of Account: ☐ Checking ☐ Savings

Routing Number _____ (For checking account draft use routing # listed on check)

Account Number _____ (DO NOT use credit/debit card)

Bank Account Owner(s): (For business accounts, list Business and Authorized Signer Name)

Name 1 First Name (Please Print) _____ Last Name _____

Email Address 1 _____

Date of Birth 1 (MM-DD-YYYY) __/__/____ SSN1 / TIN 1 _____

Name 2 First Name (Please Print) _____ Last Name _____

Email Address 2 _____

Date of Birth 2 (MM-DD-YYYY) __/__/____ SSN1 / TIN 2 _____

Bank Account Owner's Address: (For business accounts, list Business Address)

Street _____ City _____ State _____ ZIP _____

AGREEMENT:

I (we) hereby authorize and request the Company or its representative 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 contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) 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 non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and 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 in its Service Center.

I (we) authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form. Any information gathered may be disclosed to any person or entity required to receive such information by law or as I may further consent.

I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request 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.

Signature of Bank Account Owner

X _____

Date _____

Signature of Bank Account Owner, if joint account

X _____

Date _____

Please attach voided check for checking account draft or deposit slip for savings account draft.

LEAVE THIS FORM 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

You have applied for life insurance with one of the insurance companies identified above ("Company"). This notice is provided on behalf of that Company.

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.,
10101 Renner Boulevard,
Lenexa, KS 66219-9752, 800-444-7274

Portamedic,
170 Mt. Airy Rd.,
Basking Ridge, NJ 07920, 800-444-3737

Examination Management Services, Inc.,
3003 LBJ Freeway, Suite 200,
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.

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

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. To the best of your knowledge and belief has any Proposed Insured ever been diagnosed with, suffered from, or sought treatment for any of the following: a heart attack; stroke; coronary artery disease or other heart disease; cancer; diabetes; or disorder of the immune system, (excluding HIV tests), including but not limited to Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
b. To the best of your knowledge and belief has any Proposed Insured, during the last two years: (1) been confined in a hospital or other health care facility (except for childbirth without complications); (2) received medical treatment or counseling for alcohol or drug use; or (3) been advised to have any diagnostic test (excluding HIV tests) or surgery not yet performed?	☐	☐
c. To the best of your knowledge and belief is any Proposed Insured either less than 14 days old or over age 70 1/2?	☐	☐

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.

4. Complete and sign this section:

Any misrepresentation contained in this Agreement 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.

I, the Owner, have received a copy of this two-page Agreement and read it or have had it read to me and agree to be bound by the terms and conditions stated herein on the following page.

Owner Signature

X

Owner signed on (date)_____

Primary Proposed Insured (PPI) Signature (if other than Owner)

X

(If under age 16, signature of parent or Guardian)

PPI signed on (date) _____

Other Proposed Insured (OPI) Signature (if other than Owner)

X

(If under age 16 and coverage exceeds $150,000, signature of both parents required)

OPI signed on (date) _____

Writing Agent Name (please print) _____

Writing Agent # _____

Agent Instructions: Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

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 Bank Draft Authorization; (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
- $1,000,000 plus the amount of any premium paid for coverage in excess of $1,000,000 ; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

Agent Instructions: Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

HIV Testing and Consent
California Version

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

Notice and Consent for AIDS Virus (HIV) Antibody Testing

To determine your insurability, the Company has requested that you provide a sample or samples of your bodily fluids (blood, urine, and/or oral fluid) as may be allowed under state or jurisdictional law for testing and analysis. One of the tests to be performed will determine the presence or absence of antibodies to the Human Immunodeficiency Virus (HIV). The testing will be performed by a licensed laboratory in accordance with guidelines approved by the Centers for Disease Control. By signing and dating this form, you agree that this testing may be done and that underwriting decisions may be based upon the test results.

Information on HIV
HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing. Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

Pre-Testing Considerations
Many public health organizations have recommended that before taking an HIV antibody test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, before being tested.

Meaning of Test Results
A positive result, which is a series of three positive tests, does not mean you have Acquired Immune Deficiency Syndrome (AIDS). A positive test indicates that you have been infected with HIV, the causative agent for AIDS, and that you are at significantly increased risk of developing alterations of your immune system, including AIDS and AIDS-Related Complex (ARC). The test for HIV antibodies is extremely accurate and reliable. However, in rare instances, the test may be positive in individuals who are not infected with the virus (false positive) and occasionally it may be negative in persons infected with HIV (false negative), especially when infection occurred within the 3-6 months prior to testing. Your private physician, a public health clinic or an AIDS information organization in your city can provide you with further information on the medical implications of a positive test.

Disclosure of Test Results
All test results will be treated confidentially. The laboratory will report them only to the Company. The test results may be disclosed as required by law or may be disclosed to employees of the Company who have responsibility for making underwriting decisions on behalf of the Company or to outside legal counsel who needs such information to effectively represent the Company in regard to your application. The results may be disclosed to a reinsurer if the reinsurer is involved in the underwriting process. Please also be advised that the jurisdiction in which you reside may require reporting of positive HIV test results or other test results by the Company and/or the laboratory that conducts the test to a regulatory agency. Such reporting may include disclosure of personal information such as your name, address and date of birth.

If your HIV antibody test is normal (negative), no routine notification will be sent. You will be notified of an abnormal (positive or indeterminate) test result if you indicate that you desire this result be made known to you. You may also identify another person to whom you want the abnormal results released. If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

If your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB) as described in the notice given you at the time of application. The MIB is an organization of life and health insurance companies, which operates as an information exchange on behalf of its members. There will be no records with the MIB that you had a positive HIV antibody test; however, there will be a record that you have some laboratory abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request and with your authorization, will supply the information on you in its file to that member.

AGLC0335-05 Rev0516

AIG

HIV Testing and Consent
California Version

Notification of Abnormal Test Result
In the event of an abnormal result:

Send the result to me at:

Address: _____

_____

I authorize the Company to send the result to another person:

Name: _____

Address: _____

I authorize the Company to send the result to the following physician or health care provider:

Name: _____

Address: _____

Consent
I have read and I understand this HIV Testing Notice and Consent form. I voluntarily consent to the withdrawal of blood and/or collection of other bodily fluids from me, the testing of bodily fluids and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact my physician, a public health clinic or an AIDS information organization for further information and counseling if the test result is abnormal.

I understand I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

This consent will be valid for six (6) months from the date of my signature below.

Authorization

_____ _____
Name of Proposed Insured **Date of birth**

Signature of Proposed Insured or Parent/Guardian (if under age 16)

X

Date signed _____

Signature of Person Obtaining Consent

X

Date signed _____

Submit this page with the application

HIV Information Form for Insurance Applicant

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

ABOUT AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood, (as in needle sharing during IV drug use).

AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Symptoms of infection may include fever, weight loss for no apparent reason, swollen lymph glands, fatigue, diarrhea, or white spots or blemishes in the mouth.

HIV TESTING AND RESULTS

There are tests that determine the presence of antibodies or antigens to HIV. These tests do not test for AIDS; AIDS can only be diagnosed by medical evaluation.

A positive test result means that a person is infected with HIV.

A person with a positive test should:

- Have a regular medical checkup and get counseling.
- Not donate blood, sperm or organs.
- Not share needles with others.
- Avoid exchanging body fluids during sexual activity.
- Not share toothbrushes, razors or anything that could be contaminated with blood.

A negative test result is not a guarantee that a person is not infected. It takes several weeks for a positive test result to develop after a person is infected. Persons with a negative test result should begin, or continue, to practice safe sex (including condom use for sexual contact with someonThere are tests that determine the presence of antibodies or antigens to HIV. These tests do not test for AIDS; AIDS can only be diagnosed by medical evaluation.

INFORMATION AND COUNSELING RESOURCES

Further information about HIV testing and AIDS can be obtained by calling any one of the following AIDS hotlines:

In California 1-800-367-2437

National AIDS Hotline 1-800-342-AIDS

AIDS Counseling is available at these and other locations:

San Francisco AIDS Foundation
995 Market Street, Suite 200
San Francisco, CA 94103
(415) 487-3000

Central Valley AIDS Team
P.O. Box 4640
Fresno, CA 93744
(209) 264-2436

AIDS Services Foundation of Orange County
17982 Sky Park Circle, Suite J
Irvine, CA 92614-6482
(949) 809-5700

AIDS Project-East Bay
1320 Webster Street
Oakland, CA 94612
(510) 663-7979

Sacramento AIDS Foundation
1330 21st St # 100
Sacramento, CA 95814-4230
(916) 448-2437

AIDS Project Los Angeles
3550 Willshire Blvd., Suite 300
Los Angeles, CA 90010
(213) 201-1600

San Diego LGBT Resource Center
9500 Gilman Drive # 0023
La Jolla, CA 92093-0023
(858) 822-3493

ARIS Project
595 Millich Drive, Suite 104
Campbell, CA 95008
(408) 370-3272

Financial Products Disclosure
(for California only)

American General Life Insurance Company

Administrative Center: P.O. Box 9000, Amarillo, TX 79105
Home Office: 2727-A Allen Parkway, Houston, TX 77019

In the process of evaluating the purchase of any life insurance or annuity product, you should understand that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties or other costs or penalties as a result of their sale or liquidation.

Prior to purchasing the new life insurance or annuity product, you or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets.

I/We have read the above disclosure and have received a copy.

DATED: _____, 20 _____.

Owner's Signature

X _____

Owner's name (printed) _____

Joint Owner's Signature, if any

X _____

Joint Owner's name (printed) _____

Agent's Signature

X _____

Agent's name (printed) _____

AIG

Sale of Life Insurance and Annuities to Seniors in California

American General Life Insurance Company
A member of American International Group, Inc. (AIG)

This notice is to inform you of a future or a follow-up visit from your agent.

Agent's Full Name:

_____

Agent's License Number:

_____

Agent's Mailing Address:

_____

_____

_____

Agent's Telephone Number: _____

I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (indicate all that apply):

- ☐ **Life insurance, including annuities**
- ☐ **Other insurance products (specify):**

_____

_____

_____

_____

I wanted to make you aware of certain rights you have at this visit:

- **You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.**
- **You have the right to end the meeting at any time.**
- **You have the right to contact the Department of Insurance for information or to file a complaint.**

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357) or 213-897-8921
The Hotline hours are from 8:00 a.m. – 5:00 p.m.,
Monday – Friday (Except Holidays)

The following individual(s) will be coming to your home for an appointment on the _____day of _____,_____
DATE MONTH YEAR

at _____:_____
TIME

_____	_____
Agent/Attendee Name (Please Print)	**Insurance License No. (if applicable)**
_____	_____
Agent/Attendee Name (Please Print)	**Insurance License No. (if applicable)**
_____	_____
Agent/Attendee Name (Please Print)	**Insurance License No. (if applicable)**

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

American General Life Insurance Company
A member of American International Group, Inc. (AIG)

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Website (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax advisor.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

The accelerated death benefit rider for which you are applying contains a Waiver of Monthly Deduction provision that provides for waiver of the monthly deductions and the continuation guarantee account's monthly deductions, if any, under the applied-for policy under certain conditions described in the rider.

Owner's Signature

X _____

Signed on (date) _____

Agent's Signature

X _____

Signed on (date) _____

Notes: Once signed this notice should be retained by the proposed insured.

Notice To Applicant Regarding Replacement Of Long-Term Care Insurance Or Life Insurance Including Accelerated Death Benefits

American General Life Insurance Company
A member of American International Group, Inc. (AIG)

According to your application or the information you have furnished, you intend to lapse or otherwise terminate existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by American General Life Insurance Company. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and it is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

(1) Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax adviser.

(2) Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____ _____

Date Signature of Owner

Note: One signed copy of this notice shall be retained by the proposed insured and one signed copy shall be submitted with the application for coverage.

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

☐ Additional or different benefits. (please specify) _____

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ Other (please specify _____

Owner's Signature

X

Owner signed on (date) _____

Agent's Signature

X _____

Agent signed on (date) _____

Agent/Insurance Producer/Broker's name (printed) _____

Address _____

Secondary Addressee Designation
California Version

American General Life Insurance Company
The United States Life Insurance Company in the City of New York
A member of American International Group, Inc. (AIG)
Service Center: P.O. Box 818005, Cleveland, OH 44181

You have the right to designate one person, in addition to the applicant or policyowner, to receive notice of lapse or termination of a policy for nonpayment of premium. What does this mean? It means that a copy of the notice of lapse or termination that is sent to the policyowner will also automatically be sent to a second person, selected by you, who can assist you in making timely payments in order to prevent a lapse in coverage.

You are under no obligation to designate a secondary addressee, however if you would like to do so, please complete the information below and submit it with your application for life insurance or at such time as you may choose to designate a secondary addressee. **Customer Instruction:** If this designation form is for an existing policy that you own, please send the form to the following address: PO Box 818005 • Cleveland, OH 44181.

The policyowner may change the designation at any time the policy is in force by submitting a written notice to the Company containing the name, address and telephone number of the secondary addressee.

Note: Your designation on this form will replace and revoke any prior designations of secondary addressees previously made by you.

Secondary Addressee:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____

Applicant/Policyowner's Signature

X _____

Applicant/Policyowner signed on (date) _____

Applicant/Policyowner's name (printed) _____

_____

Policy Number(s), if known: _____

Index Universal Life Supplemental Application

Policy # (if known):_____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** 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

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #

This supplement must accompany the appropriate application for life insurance. This supplement and the application will be attached to and made a part of the policy.

Dollar Cost Averaging (DCA)

☐ **Please check this box if you are choosing to use DCA.**

Directions: Please check the box to select either Option A or Option B below:

☐ **Option A:** Deposit all premiums into DCA Account (not available for monthly or quarterly mode). If desired, you may allocate a portion of your premium to the Declared Interest Account below. The remainder will be deposited into the DCA Account which is allocated to Index Accounts available on the product(s) being applied for.

DCA Account (%)	_____ %	Enter % allocated to DCA Account. Premiums in DCA Account are transferred on a monthly basis based on the mode (6 transfers for semiannual and 12 transfers for annual) using the DCA Allocation percentages selected.
Declared Interest Account (%)	_____ %	Enter % allocated to the Declared Interest Account. The Declared Interest Account is not eligible to receive transfers from the DCA Account.
Total	**100%**	Note: Total allocation must equal 100%.

☐ **Option B:** Deposit only Lump Sum premium and/or 1035 exchange premiums (Internal and External) into DCA Account. By checking this box, 100% of the Lump Sum and/or 1035 exchange premiums will be allocated to the DCA Account and 12 monthly transfers will be made.

Premium/DCA Account Allocation

Directions: Please complete the section below for the product being applied for.
If you have not chosen to use DCA, please indicate how each premium received should be allocated in the "Premium Allocation (%)" column.

If you have chosen to use DCA:
For Option A, please only complete the "DCA Allocation (%)" column. The "Premium Allocation (%)" column should remain blank.
For Option B, please complete both "Premium Allocation (%)" and "DCA Allocation (%)" columns.

Total allocations in each column must equal 100%. Use whole percentages only.

Max Accumulator+ II / QoL Max Accumulator+ II

	Premium Allocation (%)	**DCA Allocation (%)**
Blend Participation Rate Account *(1-Year, utilizing ML Strategic Balanced Index®)*	_____	_____
Global Blend Participation Rate Account *(1-Year, utilizing PIMCO Global Optima Index®)*	_____	_____
High Cap Rate Account *(1-Year, No. II, utilizing S&P 500® Index)*	_____	_____
High Bonus Rate Account *(1-Year, No. I, utilizing S&P 500® Index)*	_____	_____
Declared Interest Account	_____	N/A
	100%	**100%**

Value+ Protector II / QoL Value+ Protector II

	Premium Allocation (%)	DCA Allocation (%)
Blend Participation Rate Account *(1-Year, utilizing ML Strategic Balanced Index®)*	_____	_____
Global Blend Participation Rate Account *(1-Year, utilizing PIMCO Global Optima Index®)*	_____	_____
Cap Rate Account *(1-Year, utilizing S&P 500® Index)*	_____	_____
Participation Rate Account *(1-Year, utilizing S&P 500® Index)*	_____	_____
Declared Interest Account	_____	N/A
	100%	**100%**

Other

(Use for products not listed above unless otherwise instructed.)

Product Name: _____

Directions: Please complete the section below for the product being applied for.
If you have not chosen to use DCA, please indicate how each premium received should be allocated in the "Premium Allocation (%)" column.

If you have chosen to use DCA:
For Option A, please only complete the "DCA Allocation (%)" column. The "Premium Allocation (%)" column should remain blank.
For Option B, please complete both "Premium Allocation (%)" and "DCA Allocation (%)" columns.

Total allocations in each column must equal 100%. Use whole percentages only.

	Premium Allocation %	DCA Allocation %
_____	_____	_____
_____	_____	_____
_____	_____	_____
	100%	**100%**

Agreement: I acknowledge that I have read this supplemental application or that it has been read to me. The completed supplemental application is true and complete to the best of my knowledge and belief. I agree that this supplemental application shall form a part of my application for insurance.

Owner Signature

Owner signed on (date) _____

AGENT INSTRUCTIONS: Submit this form with the policy application packet.

Rider & Benefit Reference Sheet

Shown below are a listing of *optional* riders and available for selection by product line. Please select riders/benefits desired on the application and complete any supplemental information requested. Please refer to sales materials for state variations and state approvals as well as inherent benefits that will be automatically included with the base product.

Term Products	**Houston Portfolio**	**Nashville Portfolio**
Rider/Benefit Name	**Select-a-Term**	**QoL Flex Term**
Accidental Death Benefit	X	X
Child Rider	X	X
Terminal Illness Rider	X	
Waiver of Premium	X	X

Universal Life Products	**Houston Portfolio**	**Nashville Portfolio**
Rider/Benefit Name	**AG Secure Lifetime GUL 3 [2]**	**QoL Guarantee Plus GUL II [2]**
Accidental Death Benefit	X	X
Child Rider	X	X
Chronic Illness Rider (AAS)	X	X
Enhanced Surrender Value Rider	X	X
Lifestyle Income Rider	X	X
Terminal Illness Rider	X	
Waiver of Monthly Deduction	X	X

[1] Product requires a signed illustration. [2] Product requires a signed quotation.
Note: DO NOT submit this sheet with the application packet. For agent use only; not for dissemination to the public.

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Rider & Benefit Reference Sheet

Indexed Universal Life Products	Houston Portfolio		Nashville Portfolio	
Rider/Benefit Name	**Max Accumulator+ II [1]**	**Value+ Protector II [1]**	**QoL Value+ Protector II [1]**	**QoL Max Accumulator+ II [1]**
Accidental Death Benefit	X	X	X	X
Child Rider	X	X	X	X
Chronic Illness Rider (AAS)	X	X	X	X
Early Cash Value Rider	X			X
Income for Life Rider	X			X
Overloan Protection	X	X	X	X
Protected Premium		X	X	
Select Income Rider	X	X	X	X
Terminal Illness Rider	X	X		
Waiver of Monthly Deduction	X	X	X	X
Waiver of Specified Premium	X			X

[1] Product requires a signed illustration. [2] Product requires a signed quotation.

Note: DO NOT submit this sheet with the application packet. For agent use only; not for dissemination to the public.

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NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

For Distribution by Insurers, Agents, and Brokers

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Recovery
An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, also may be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident
An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

Married Resident
Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $126,420 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $3,161 in monthly income, whichever is greater.

Fair Hearings and Court Orders
Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $126,420 in countable resources. The order also may allow the at-home spouse to retain more than $3,161 in monthly income.

Real and Personal Property Exemptions
Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- One principal residence. One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.
- The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.
- Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- Real property used in a business or trade. Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

- IRAs, KEOGHs, and other work-related pension plans. These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- Personal property used in a trade or business.
- One motor vehicle.
- Irrevocable burial trusts or irrevocable prepaid burial contracts.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part

1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement.

To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Purchaser signature	Date
Spouse's signature	Date
Legal representative signature	Date

Supplemental Application for Chronic Illness Accelerated Death Benefit Rider

American General Life Insurance Company, Houston, TX
A member of American International Group, Inc. (AIG)

This is a supplement to the application for the Life Insurance for the Primary Proposed Insured. Please complete if the Chronic Illness Accelerated Death Benefit Rider is being elected.

(Check the box that applies)

☐ New Application ☐ Reinstatement ☐ Base Policy Specified Amount Increase

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1. Primary Proposed Insured

First Name _____ MI ____ Last Name _____ Date of Birth _____

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2. Benefits (Complete for New Application Only)

A. Maximum Monthly Benefit Percentage: ☐ **2%** ☐ **4%**

B. Lifetime Maximum Benefit Percentage: _____**%**

Note: If the Chronic Illness Accelerated Death Benefit Rider is approved and added to your policy, the policy will also include, at no additional charge, a Terminal Illness Accelerated Death Benefit Rider. The Disclosure of Accelerated Death Benefits form must be completed for the Chronic Illness Accelerated Death Benefit Rider, if required by the state of issue.

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3. Health Questions – In this section, "you" refers to the Primary Proposed Insured.

A. During the last 12 months, have you:

1. Required assistance or supervision of any kind to perform an activity of daily living (ADLs) which consist of: Mobility (including the use of a pronged cane), taking medications, dressing, eating, walking, bathing or toileting? ☐ Yes ☐ No

2. Used any of the following:

☐ Yes ☐ No - catheter;	☐ Yes ☐ No - chair lift;	☐ Yes ☐ No - dialysis;
☐ Yes ☐ No - motorized scooter;	☐ Yes ☐ No - oxygen equipment;	☐ Yes ☐ No - respirator;
☐ Yes ☐ No - walker;	☐ Yes ☐ No - or wheelchair;	☐ Yes ☐ No - quad or three-pronged cane

3. Been advised to enter, reside in or require any of the following:

☐ Yes ☐ No - nursing home	☐ Yes ☐ No - assisted living facility
☐ Yes ☐ No - long term care facility	☐ Yes ☐ No - residential care facility
☐ Yes ☐ No - adult day care	☐ Yes ☐ No - skilled nursing facility (SNF)
☐ Yes ☐ No - required home health care	☐ Yes ☐ No - Continuing Care Retirement Community (CCRC)

B. During the last 3 years, have you:

1. Used insulin to treat Diabetes? ☐ Yes ☐ No

2. Been diagnosed or treated by a licensed health care provider for Diabetes WITH COMPLICATIONS* (*such as eye, kidney, or nerve damage)? ☐ Yes ☐ No

3. Been diagnosed or treated by a licensed health care provider for Diabetes AND:
☐ Yes ☐ No - Heart Disease ☐ Yes ☐ No - Stroke ☐ Yes ☐ No - Peripheral Vascular Disease

C. Have you EVER been diagnosed with, been treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Alzheimer's disease ☐ Yes ☐ No
2. Dementia ☐ Yes ☐ No
3. Mild Cognitive Impairment (MCI) ☐ Yes ☐ No
4. Organic Brain Syndrome (OBS) ☐ Yes ☐ No
5. Amputation due to disease ☐ Yes ☐ No
6. ALS (Lou Gehrig's disease) ☐ Yes ☐ No
7. Stroke ☐ Yes ☐ No

8. Cerebral Vascular Accident (CVA) ☐ Yes ☐ No
9. Transient Ischemic Attack (TIA) ☐ Yes ☐ No
10. Organ Transplant (other than corneal) ☐ Yes ☐ No
11. Multiple Sclerosis ☐ Yes ☐ No
12. Huntington's Chorea ☐ Yes ☐ No
13. Muscular Dystrophy ☐ Yes ☐ No
14. Myasthenia Gravis ☐ Yes ☐ No
15. Macular Degeneration ☐ Yes ☐ No
16. Blindness ☐ Yes ☐ No
17. Optic Neuritis ☐ Yes ☐ No
18. Osteoporosis with fractures ☐ Yes ☐ No
19. Parkinson's disease ☐ Yes ☐ No
20. Post-Polio Paralytic Syndrome ☐ Yes ☐ No
21. Polymyositis ☐ Yes ☐ No
22. Scleroderma ☐ Yes ☐ No
23. Memory loss ☐ Yes ☐ No
24. Unplanned weight loss greater than 15 pounds within the last 2 years ☐ Yes ☐ No
25. Arthritis with narcotic pain medication within the past 12 months ☐ Yes ☐ No

D. Do you have a parent or sibling diagnosed or treated by a licensed health care provider for Huntington's chorea or Polycystic Kidney Disease? ☐ Yes ☐ No

If any question in 3. A-D was answered yes, the rider is not available for the Primary Proposed Insured and this supplemental application should not be completed or submitted.

E. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Disorientation ☐ Yes ☐ No
2. Multiple falls ☐ Yes ☐ No
3. Injury due to a fall ☐ Yes ☐ No
4. Chest Pain ☐ Yes ☐ No
5. Loss of balance ☐ Yes ☐ No
6. Loss of strength ☐ Yes ☐ No
7. Tremors ☐ Yes ☐ No
8. Dizziness ☐ Yes ☐ No

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4. Lifestyle / Supplemental Information – In this section, "you" refers to the Primary Proposed Insured.

A. Do you have a handicap sticker, handicap placard, or handicap license plate? (Give reason below) ☐ Yes ☐ No

B. In the last 24 months, have you had to limit or been advised by a licensed health care provider to limit, reduce, discontinue or restrict any activities or hobbies? (If yes, give reason below) ☐ Yes ☐ No

C. In the past 24 months, have you required assistance with any Instrumental Activities of Daily Living (IADL's) which consist of: shopping, arranging transportation, housekeeping, cooking, laundry, meal preparation, managing finances, managing medications, using the telephone or used a straight cane? (If yes, give reason below) ☐ Yes ☐ No

D. Within the past 5 years, have you received any:
☐ Yes ☐ No - long term care benefits ☐ Yes ☐ No - disability income benefits
☐ Yes ☐ No - Social Security Disability Income Benefits
(If yes, please provide details in **Section 5, Remarks**.)

E. Within the past 5 years, have you been declined for: Long term care insurance; Long term care insurance rider or Accelerated Death Benefit Rider attached to a life insurance policy or an annuity contract? (If yes, please provide the name of the company, date and the reason, if known, in **Section 5, Remarks**.) ☐ Yes ☐ No

5. Remarks

_____

_____

_____

_____

6. Replacement Question

You are applying for a life insurance policy with an accelerated death benefit rider. By applying for this policy, do you intend to replace any Long term care (LTC) insurance policy; Long term care insurance rider or Accelerated Death Benefit Insurance Rider attached to a life insurance policy or an annuity contract that is currently in force? ..... ☐ Yes ☐ No

I, the Primary Proposed Insured signing below, agree that I have read the statements contained in this application supplement and that all statements and answers given in this application supplement are true and complete to the best of my knowledge and belief. 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 the contestable period.

I understand that benefits under the Chronic Illness and Terminal Illness riders are provided through an accelerated death benefit option, and that if I exercise the accelerated benefit option, any beneficiary I designate will receive a reduced death benefit.

I acknowledge, that I have read the Important Notice and have received a copy of the notice.

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

The accelerated death benefit rider for which you are applying contains a Waiver of Monthly Deduction provision that provides for waiver of the monthly deductions and the continuation guarantee account's monthly deductions, if any, under the applied-for policy under certain conditions described in the rider.

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.

X _____ _____

Signature of Primary Proposed Insured Date

Writing Agent Name: _____

Last First

Writing Agent Number: _____ Agency Number: _____

X _____ _____

Signature of Licensed Writing Agent Date

Notice Regarding Replacement

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way, you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature

X _____

Agent's Signature

X _____

Applicant signed on (date) _____

Applicant's name (printed) _____

Insured's Name	Company	Contract Number