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)

Draft will occur on the date of issue or the date of submit unless a preferred withdrawal date is chosen below.

Subsequent Premiums, if different: $ _____

☐ Draft Only Subsequent Premiums

Check/Complete one of the following:

☐ Collected check with application in the amount of $ _____.

☐ Will collect check 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 the first premium 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 (Please Print) _____ Email Address 1 _____

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

Name 2 (Please Print) _____ Email Address 2 _____

Date of Birth 2 (MM-DD-YYYY) _____ SSN2 / TIN 2 _____

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

Street _____ City _____ State _____ ZIP _____

AGLC108493-2015 Rev0516

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). 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

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, 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)

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 305355 • Nashville, TN 37230-5355.

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.) The supplement and the application will be attached to and made a part of the policy.

Directions: Please complete the appropriate section below for the product being applied for. Indicate how each premium received should be allocated. These allocations must match the information on the signed illustration. **Total allocations must equal 100%. Use whole percentages only.**

Max Accumulator+ / QoL Max Accumulator+

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)*

Declared Interest Account _____%

High Bonus Rate Account _____ %
(*1-Year, No. I, utilizing S&P 500® Index)*

Value+ Protector / QoL Value+ Protector

Blend Participation Rate Account _____ %
(*1-Year, utilizing ML Strategic Balanced Index™)*

Participation Rate Account_____ %
(*1-Year, utilizing S&P 500® Index)*

Cap Rate Account _____ %
(*1-Year, utilizing S&P 500® Index)*

Declared Interest Account _____ %

Other

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

Product Name: _____

Write in account name and indicate how each premium received should be allocated.

_____ _____%

_____ _____%

_____ _____%

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

X _____

Owner signed on (date)_____

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

Notice Regarding Premium Default Options

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

If you are applying for a term life insurance policy, that policy does not automatically contain a benefit that can operate to prevent the lapsing of the policy for failure to pay necessary premiums. You may apply for a rider to provide a waiver of premium benefit in the event of your total disability; however, there is an additional charge for such coverage, and the issuance of such coverage is not guaranteed.

If you are applying for a universal life insurance policy containing an accelerated death benefit rider for which there is no separately stated charge, cost of insurance charges, rider premiums, and other fees and charges will be deducted from the policy's Accumulation Value pursuant to the terms of the applicable policy. The policy does not automatically contain a benefit that can operate to prevent the lapsing of the policy for failure to pay necessary premiums. You may apply for a rider to provide a waiver of monthly deduction benefit or a total disability monthly benefit in the event of your total disability; however, there is an additional charge for such coverage, and the issuance of such coverage is not guaranteed.

If you are applying for a universal life insurance policy containing an accelerated death benefit rider for which there is a separately stated charge, the policy will provide a Waiver of Monthly Deduction Benefit. If Accelerated Benefits are received under the Periodic Benefit Payment Option provision of the Rider, then, during each Benefit Period, all or a portion of the Policy's monthly deduction and the continuation guarantee account's monthly deduction, if any, will be waived. The amount of the monthly deduction to be waived will be the Policy's monthly deduction, and the continuation guarantee account's monthly deduction, if any, multiplied by the Waiver of Monthly Deduction Benefit Percentage shown on the applicable Rider Schedule. Such waiver will begin on the date Monthly Benefits begin under this Rider and will continue while the Policy remains in force and Monthly Benefits are paid. Such payment of the Waiver of Monthly Deduction Benefit will not guarantee that the policy will remain in force during or after a Benefit Period. Continuation of the policy while the Waiver of Monthly Deduction Benefit is being paid under the rider will depend upon the amount of such waiver benefit and the payment of any premiums and will be subject to the Grace Period and Termination provisions of the policy. You may be required to pay premiums during and/or after a Benefit Period to keep the policy in force.

I acknowledge that I have read or have had read to me this Notice Regarding Premium Default Options and have received a copy of it.

Owner's Signature

X

Owner signed on (date)_____

Owner's name (printed)_____

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

1. Primary Proposed Insured

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

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.

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

---

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

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) _____

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, may also 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 $123,600 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 $3,090 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 $123,600 in countable resources. The order also may allow the at-home spouse to retain more than $3,090 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 memberwhose 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 unavailableand is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change theform 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 forthose 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

Form **4506T-EZ**

(July 2017)

Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

► **Request may not be processed if the form is incomplete or illegible.**

► **For more information about Form 4506T-EZ, visit *www.irs.gov/form4506tez*.**

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number or individual taxpayer identification number on tax return**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name	Telephone number
NCS TRV PROCESSING	(800) 582-7066

Address (including apt., room, or suite no.), city, state, and ZIP code

P.O. BOX 321, EGG HARBOR CITY, NJ 08215 800-582-7066

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

2017 | 2016 | | |

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS will notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** spouse must sign. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Sign Here	**Signature** (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	Spouse's signature	Date	

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form 4506T-EZ, such as legislation enacted after it was published, go to *www.irs.gov/form4506tez*.

Caution. Do not sign this form unless all applicable lines have been completed.

Purpose of form. Individuals can use Form 4506T-EZ to request a tax return transcript for the current and the prior three years that includes most lines of the original tax return. The tax return transcript will not show payments, penalty assessments, or adjustments made to the originally filed return. You can also designate (on line 5) a third party (such as a mortgage company) to receive a transcript. Form 4506T-EZ cannot be used by taxpayers who file Form 1040 based on a tax year beginning in one calendar year and ending in the following year (fiscal tax year). Taxpayers using a fiscal tax year must file Form 4506-T, Request for Transcript of Tax Return, to request a return transcript.

Use Form 4506-T to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506T-EZ to the address below for the state you lived in when the return was filed.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

If you filed an individual return and lived in:	Mail or fax to the "Internal Revenue Service" at:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301 855-587-9604
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888 (855) 800-8105
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999 855-821-0094

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506T-EZ must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506T-EZ within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked

Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506T-EZ exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. If you request a transcript, sections 6103 and 6109 require you to provide this information, including your SSN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506T-EZ will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 9 min.; **Preparing the form,** 18 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506T-EZ simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

Agent Certification Form

☐ **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)

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.

Insured's Social Security Number _____ Policy Number _____

Additional Insured's Social Security Number_____

This form must be completed prior to taking any application for life insurance on an individual age 67 or older. The Company may also request agents to complete this Form in other situations where it is deemed appropriate.

Carefully review this Form and Company Field Bulletins regarding Investor Owned Life Insurance and Stranger Owned Life Insurance, and complete the certification below that applies to the transaction; except, however, if part or all of the premium paid toward this policy is being financed and you cannot sign the certification, you must not take the application.

Non-Premium Financing Certification

None of the premiums for the policy sought with the application for (Insured)_____ or for _____(Additional Insured) dated_____will be financed other than pursuant to a split dollar agreement, including a family's private split dollar agreement.

Agent's Signature X _____ **Agent signed on** (date) _____

Premium Financing Certification

1) I have reviewed and am familiar with all aspects of the premium financing proposal.
2) Based upon my review of the financing proposal, I believe that the costs associated with this premium financing proposal are such that assuming no change in the insured/additional insured's health, it is more likely than not that the insured/additional insured will maintain the policy in force for the benefit of his/her beneficiaries and those beneficiaries will receive more than 50% of the policy death benefit.
3) The insured/additional insured is not receiving any cash payment, borrowing funds in excess of those required to pay the scheduled premiums and interest, or receiving any other consideration as an inducement to participate in this transaction.
4) Within the past 24 months has the insured/additional insured had a life expectancy calculation? ☐ Yes ☐ No
   All life expectancy calculations performed on any proposed insured during the past 24 months must be submitted with any application for review and consideration.
5) There is no prearranged agreement to transfer the policy nor will the policyholder have a prearranged option or right of first refusal to transfer the policy to a third party.
6) All sales materials used in connection with the solicitation and sale of this policy were either produced by the life insurance company or have been submitted and approved by the Company.
7) I have read the Field Bulletins regarding Investor Owned Life Insurance, Stranger Owned Life Insurance and Viatical Transactions, and believe this transaction is in compliance with the company policies as set forth in those Bulletins regardless of whether the lending program is a recourse or non-recourse transaction.

All or part of the premiums paid towards this policy are being financed. I have read the statements set forth above and hereby certify that the statements are all true with regard to the application for (Insured) _____ _____ and _____ (Additional Insured) dated _____ .

Agent's Signature X _____ **Agent signed on** (date) _____

AIG

Life Insurance Application
Part B (Medical History)
Policy # (if known): _____
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)

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

(Complete separate Part B for each Proposed Insured.)

First Name _____ MI ____ Last Name _____ Date of Birth _____ Social Security # _____

Medical History

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

1. Physician Information

Name, address and phone number of the Proposed Insured's personal physician(s). *(If no personal physician, provide name, address and phone number of last doctor consulted or medical facility visited or to which admitted.)*

Name _____ Phone _____

Address _____ City, State _____ ZIP _____

Date of last office visit, reason, findings and treatment: _____

_____

_____

_____

_____

2. Pending Medical Appointments

Does the Proposed Insured have a pending medical appointment or have the intent to make a medical appointment within the next three months? ..... ☐ yes ☐ no

(If yes, provide date, name, address and phone number of physician, and reason for visit.) _____

_____

_____

3. Build

A. Admitted Height and Weight _____ ft _____ in _____ lbs
(Examiners: Also record measured height and weight on Exam page 1.)

B. Birth Weight (if Proposed Insured is less than 1 year old) _____ lbs _____ oz

C. Has the Proposed Insured had any weight change in excess of 10 lbs in the **past year**? ..... ☐ yes ☐ no
If yes, complete the following: Loss _____lbs Gain _____lbs Reason* _____

*If weight change was due to pregnancy, provide due/delivery date and pre-pregnancy weight:
Due/Delivery Date _____ Pre-Pregnancy Weight _____lbs

4. Family History

A. Complete the information in the grid below.

Age if Living	Age at Death	Cause of Death	History of Heart Disease? (Coronary Artery Disease or Heart Attack)	History of Cancer?
Father _____	_____	_____	☐ no ☐ yes Age of Onset _____ Details _____	☐ no ☐ yes Age of Onset _____ Type _____
Mother _____	_____	_____	☐ no ☐ yes Age of Onset _____ Details _____	☐ no ☐ yes Age of Onset _____ Type _____
Siblings_____	_____	_____	☐ no ☐ yes Age of Onset _____ Details _____	☐ no ☐ yes Age of Onset _____ Type _____

B. Other than as stated in 4A, has any immediate family member of the Proposed Insured (parents, siblings or children), been diagnosed with heart disease prior to age 50, Amyotrophic Lateral Sclerosis (ALS), polycystic kidney disease, porphyria, cardiomyopathy, sickle cell anemia, Huntington's disease, aneurysm, or cancer? ☐ yes ☐ no

(Please provide details including type, age of onset, and relationship(s) to Proposed Insured.)

Details: _____

_____

C. Is there a family history of mental illness, suicide, or substance abuse in your immediate family (parents and siblings only)? ☐ yes ☐ no

(Please provide details including diagnosis and relationship(s) to Proposed Insured.)

Details: _____

_____

5. Personal Health History

A. Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) high cholesterol? ☐ yes ☐ no
   Date of diagnosis _____ most recent level _____treatment _____
2) high blood pressure? ☐ yes ☐ no
   Date of diagnosis _____ most recent reading _____treatment _____
3) diabetes? ☐ yes ☐ no
   Date of diagnosis _____ most recent HgbA1c _____treatment _____

B. Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) coronary artery disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, or other disorder or disease of the heart? ☐ yes ☐ no
2) blood clot, clotting disorder, aneurysm, stroke, transient ischemic attack (TIA), peripheral vascular disease, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☐ no
3) cancer, leukemia, lymphoma, tumors or growths, masses, cysts or other similar abnormalities? ☐ yes ☐ no
4) pituitary, thyroid, adrenal, or disease or disorder of any other glands? ☐ yes ☐ no
5) anemia, hemophilia, sickle cell anemia, or other disease or disorder of the blood, lymphatic system or immune system? (excluding HIV tests) ☐ yes ☐ no
6) colitis, Crohn's disease, hepatitis, colon polyps, or any disorder of the throat, esophagus, gall bladder, stomach, liver, pancreas or intestine? ☐ yes ☐ no
7) disorder of the kidneys, bladder, prostate or reproductive organs or protein or blood in the urine? ☐ yes ☐ no
8) asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea or other breathing or lung disorder? ☐ yes ☐ no
9) seizures, cerebral palsy, Down syndrome, autism spectrum disorder, Parkinson's disease, multiple sclerosis, severe headaches, disorder or injury of the brain, spinal cord or nervous system? ☐ yes ☐ no
10) attention deficit hyperactivity disorder (ADHD), memory loss, dementia or Alzheimer's disease? ☐ yes ☐ no
11) anxiety, eating disorder, depression, suicide attempt, bipolar disease, post-traumatic stress disorder (PTSD), hallucinations, psychosis, schizophrenia, or other psychiatric conditions? ☐ yes ☐ no
12) arthritis, muscle disorders, Amyotrophic Lateral Sclerosis (ALS), fibromyalgia, muscular dystrophy, chronic pain, connective tissue disease, autoimmune disease or other bone or joint disorders? ☐ yes ☐ no
13) glaucoma, macular degeneration, optic neuritis or any disorder of the eyes, ears or skin? ☐ yes ☐ no

(For any yes answers, provide details such as: date of diagnosis, date of last treatment; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details _____

_____

_____

_____

_____

_____

C. Other than previously stated, has the Proposed Insured taken any medications, had treatment or therapy or been under medical observation within the **past 12 months**? ☐ yes ☐ no

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

Details _____

_____

_____

D. Has the Proposed Insured in the **past 12 months** had but NOT consulted a medical professional for:

1) fainting spells, dizziness, numbness, headaches, convulsions or paralysis? ☐ yes ☐ no
2) pain or discomfort in the chest, shortness of breath, hoarseness, unexplained cough or coughing up of blood? ☐ yes ☐ no
3) disorders of the stomach, intestines or rectum, rectal bleeding or blood in the urine? ☐ yes ☐ no
4) sores that have not healed or changes in the appearance of a mole? ☐ yes ☐ no
5) anxiety, depression, loss of memory, disorientation or confusion? ☐ yes ☐ no

(For any yes answers, list condition such as: date of first occurrence; symptoms; and how treated.)

Details _____

_____

_____

E. Within the **past 5 years**, has the Proposed Insured used alcoholic beverages? ☐ yes ☐ no

If yes, Average number of drinks per week _____ Maximum number of drinks per day _____

Type (Beer, Wine, Liquor) _____ Date of last use _____

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

1) used cocaine, heroin, methamphetamine, hallucinogens, stimulants or any other habit-forming drug except as prescribed by a medical professional? ☐ yes ☐ no
2) used marijuana (prescribed or otherwise) in any form? ☐ yes ☐ no
3) used a controlled substance or prescription drug in a manner other than prescribed by a physician? ☐ yes ☐ no
4) sought or received medical advice, counseling or treatment by a medical professional to discontinue or reduce the use of alcohol or drugs, including prescribed controlled substances? ☐ yes ☐ no

If answered "Yes" to F1 through F4, please provide details below.

Type of drug(s) and/or alcohol _____ Date last used _____

Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly Amount typically used: _____

Name(s) of doctor/facility _____ Phone _____

Address _____ City, State _____ ZIP _____

Treatment Dates _____

Support group(s) _____

Was treatment or support group attendance court ordered? ☐ yes ☐ no

Details of any drug or alcohol related arrests _____

G. Has the Proposed Insured **ever** been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☐ no

(If yes, provide details such as: date of diagnosis; name, address, and phone number of doctor.)

Details _____

_____

_____

H. Other than previously stated, in the **past 5 years**, has the Proposed Insured:

1) been hospitalized, consulted a member of the medical profession or had any illness, injury or surgery? ☐ yes ☐ no
2) been advised by a member of the medical profession concerning any abnormal diagnostic test results, been advised to see a specialist, or been advised to have any diagnostic test, hospitalization, surgery, or treatment that was NOT completed (except for those tests related to the Human Immunodeficiency Virus), or does the proposed insured have any test results pending? ☐ yes ☐ no
3) undergone any self-administered laboratory test other than those for pregnancy or Human Immunodeficiency Virus (HIV)? ☐ yes ☐ no
4) made a claim for or received benefits, compensation, payment or pension for any injury, sickness, disability, or impaired condition? ☐ yes ☐ no

(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details _____

_____

_____

_____

_____

I. Has the Proposed Insured had any emergency room, emergency clinic, walk-in clinic, or free clinic visits during the **past 5 years**? ☐ yes ☐ no

(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)

Details_____

J. Has the Proposed Insured **ever** been advised to or chosen to enter a nursing home, hospice, or assisted living facility? ☐ yes ☐ no

(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)

Details_____

K. Within the **last 2 years** has the Proposed Insured:

1) experienced fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing, or shortness of breath? ☐ yes ☐ no
2) received home health care services, physical therapy or rehabilitation therapy? ☐ yes ☐ no
3) required the use of a cane, walker, wheelchair, other assistive device, or resided in an assisted living facility? ☐ yes ☐ no
4) required assistance or supervision with or had any limitations in performing any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)? ☐ yes ☐ no
5) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside of the home or preparing meals? ☐ yes ☐ no

(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details_____

L. Has the Proposed Insured been treated for or been diagnosed with, or does the Proposed Insured have, any other medical, physical, or psychological condition **NOT** disclosed above? ☐ yes ☐ no

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

Details_____

Agreement and Signatures

I, the Proposed Insured 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.

Fraud

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE OF PROPOSED INSURED

Signed at *(city, state)* _____ On *(date)* _____

X _____

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

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

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

If Agent recorded information

_____ _____ _____

Writing Agent Name *(Please print)* | Writing Agent # | Date

X _____

Writing Agent Signature

If Tele-interviewer recorded information

_____ _____ _____

Name *(Please print)* | Company | Date

If Paramedical Examiner/Medical Doctor recorded information

Examiner Address _____ **Paramed: Use company stamp below.**

Examiner Phone # _____

Examiner Name _____

X _____ Date _____

Examiner Signature

EXAMINATION
Physical Measurements

1. Proposed Insured

A. _____ _____ _____
First Name MI Last Name

B. Build: Measured Height *(in shoes 1in heel or less)* _____ ft _____in Measured Weight *(clothed)*_____lbs

1) Did you measure the Proposed Insured's height..... ☐ yes ☐ no

2) Did you weigh Proposed Insured? ..... ☐ yes ☐ no

3) If unable to obtain measured height or weight, please provide reason _____

C. Blood Pressure and Pulse
Blood Pressure: Three readings required, spaced at least five minutes apart.
Pulse: Only required once if heart rate between 50-100 bpm, otherwise obtain three measurements.
Select cuff size: ☐ Standard BP cuff ☐ Large BP cuff

	1st Reading	2nd Reading	3rd Reading
Systolic BP			
Diastolic BP			
Pulse Rate			
Irregularities Per Min.			

D. Have any of the following been completed in conjunction with this exam? ☐ Blood ☐ Urine ☐ EKG

E. Examiner observations and remarks

1) Is appearance unhealthy or older than stated age?..... ☐ yes ☐ no

2) Are there any obvious physical abnormalities?..... ☐ yes ☐ no

3) Did anyone assist the Proposed Insured in answering any questions?..... ☐ yes ☐ no

4) Does Proposed Insured use any device to aid in locomotion (e.g. cane, walker, wheelchair)? ..... ☐ yes ☐ no

5) Does Proposed Insured use any other assistive device not previously disclosed (e.g. oxygen, prosthetic limb)? ... ☐ yes ☐ no

6) Does Proposed Insured seem confused, disoriented or otherwise impaired?..... ☐ yes ☐ no

7) Does Proposed Insured have any speech difficulties or use a voice prosthesis?..... ☐ yes ☐ no

8) Was this appointment conducted in a language other than English? (if yes, indicate language and who provided interpretation or translation services) ..... ☐ yes ☐ no

9) Do you have any pertinent information or observation not previously disclosed? ..... ☐ yes ☐ no

Details_____

_____

_____

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

_____

_____

Report By Examining Medical Doctor

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

1) Heart

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

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

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

d. Murmur is:

☐ Constant Transmitted to where?_____

☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere

☐ Systolic *(Give details)* _____

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

After valsalva, murmur is:

☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

Your impression _____

_____

_____

Report by Examining Medical Doctor *(continued)*

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

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

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

d) Respiratory system?..... ☐ yes ☐ no

Details_____

_____

_____

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

Details_____

_____

_____

f) Genito-urinary system?..... ☐ yes ☐ no

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

Signature

Paramedical Examiner/Medical Doctor Signature

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

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

Examiner Address _____

Examiner Phone # _____

Examiner Name _____

Examiner Signature **X** _____

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

Certification of Trust

☐ **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)

1. **Account Information** *(Indicate one of the following)*

This form is being completed for an:

☐ Existing life insurance policy ☐ Existing annuity contract ☐ Existing Mutual Fund Account

Existing Policy/Contract/Account Number(s) _____

☐ Application for life insurance policy ☐ Application for an annuity contract

2. **Trust Information**

Full legal name of Trust _____

Date on which Trust was executed _____

Trust's tax identification number _____

State where Trust established _____ ☐ Revocable Trust ☐ Irrevocable Trust

3. **Grantor Trust Information** *(complete only for annuities and modified endowment contracts)*

Is this Trust a Grantor Trust pursuant to IRC Sections 671 to 678? ☐ Yes ☐ No

A grantor trust is a trust under which the Grantor or someone other than the Grantor is treated as the owner of the trust assets for tax purposes under IRC Sections 671-678.

If yes, provide the following:

Grantor Name_____ Social Security Number _____

Grantor Name_____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

4. **Trustee Authority**

Names of all Trustees authorized to act on behalf of the Trust_____

_____

If more than one Trustee:

☐ Any Trustee is able to act independently ☐ All Trustees must act jointly ☐ Other (please specify) _____

5. **Trustee Declaration and Signature Information**

All currently acting trustees must sign. This form will supersede any previously provided certifications.

By signing below, each and all of the undersigned hereby:

(a) represent they constitute all of the currently acting trustees of the Trust and that the Trust authorizes the Trustee(s) to purchase, own, and administer life insurance policies and/or annuity contracts on the life of the Insured(s)/Annuitant(s);

(b) declare that the Trust has not been revoked, modified, or amended in any manner that would cause the representations contained herein to be incorrect and agree to provide a new Certification of Trust if the Trust is amended in any manner that changes any representations made in this Certificate, including any changes to the acting Trustees;

(c) understand and agree that the life insurance company named above ("Life Company") (i) does not review trust documents, (ii) will administer the policy or contract in accordance with its standard procedures and has no obligation to administer in accordance with any terms of the Trust, (iii) may rely on the instructions and representations of the Trustee(s), and (iv) will have no responsibility to determine whether any instructions or representations of the Trustee(s) are consistent with the authorities granted to the Trustee(s) by the Trust document;

5. **Trustee Declaration and Signature Information** *(con't)*

(d) agree to defend, indemnify and hold the Life Company, its parents, subsidiaries, and affiliates, and their directors, officers, employees and agents harmless for and against any and all claims, demands, liabilities, damages, costs or expenses, including, but not limited to, reasonable attorney's fees, which it may suffer or incur by reason of its reliance upon any statements contained herein;

(e) agree to provide additional information regarding the Trust if required by the Life Company;

(f) acknowledges that the Trustee(s) have had an opportunity to consult with its own legal and/or tax counsel in preparation of the Certification of Trust and that the Trustee(s) are solely responsible for the tax consequences arising from this Policy/Contract being held by a trust;

(g) represent that no trustee of the Trust is an agent of record, servicing agent, solicitor, insurance producer, financial representative, investment advisor or related financial institution, broker/dealer or insurance agency or any individual or entity acting in a similar capacity involved in the sale, solicitation or placement of this contract/policy (such individuals and entities collectively "Distributor"), unless such Distributor is a member of Insured's/Annuitant's immediate family;*

(h) represent and certify that (i) the Trust and each beneficiary under the Trust has an insurable interest** in the Insured(s)/Annuitant(s) listed on this form, (ii) is not aware of any agreement or arrangement whereby the Insured(s)/Annuitant(s) has received a payment or anything else of value in exchange for permission to use his/her life on the Policy/Contract, and (iii) understand that the Life Company reserves the right to terminate the contract consistent with applicable law if it discovers a misstatement with respect to the insurable interests between the Trust and the Insured(s)/Annuitant(s).

This paragraph (h) does not apply because:

☐ Trust was designated as beneficiary for an Individual Retirement Annuity and/or employer sponsored retirement plan or program (such as 401(a)/(k), 403(b), or 457(b)).

☐ Other_____

**If the distributor is NOT a member of the insured's immediate family, then such Distributor and the Insured/Annuitant must complete an Acknowledgment and Release Form and submit same to the Company.*

***Generally, an interest is insurable if a familial relationship and/or economic interest exists. A familial relationship can only exist between individuals, and the relationship generally includes those persons related by blood or by law. An economic interest exists when the contract owner has a lawful and substantial economic interest in having the life, health, or bodily safety of the life that triggers the death benefit preserved. Charitable and not-forprofit organizations are exempt from insurable interest requirements.*

Trustee #1

Name _____ Signature _____

Date_____ Phone _____ State of_____ County of _____

Trustee #2

Name _____ Signature _____

Date_____ Phone _____ State of_____ County of _____

Trustee #3

Name _____ Signature _____

Date_____ Phone _____ State of_____ County of _____

6. **Insured/Annuitant Information** *(This section not required where annuitant designates a trust as beneficiary for an Individual Retirement Annuity and/or employer-sponsored retirement plan or program (such as 401(a)/(k), 403(b) or 457(b)) or (2) with a permissible explanation under Section 5(h) of this form.)*

By signing below, each and all of the undersigned hereby:

(a) certifies that his/her life is being used as the insured for the life insurance policy or measuring life for the annuity contract, as applicable, and consents to the use thereof;

(b) certifies that he/she has not entered into any agreement or arrangement whereby he/she has been paid, or received any other benefit, in exchange for permission to use his/her life for the life insurance policy or annuity contract, as applicable. Such an arrangement or agreement may be deemed a fraudulent act.

Insured/Annuitant's Signature

X

Insured/Annuitant Name (printed) _____

_____

Insured/Annuitant signed on (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