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Life Kit

NEW JERSEY

AIG®

Policies issued by American General Life Insurance Company, a member of American International Group, Inc. (AIG)

AIG

New Business Transmittal Form

☐ AIG Financial Network ☐ AIG Partners Group

Policy Number _____ Applicant Name _____ DOB _____

Office Number _____ Office Name _____

Agent/Service Number _____ Agent Name _____

☐ New Application
☐ Underwriting Requirements
☐ Delivery Requirements
☐ Reissue (Indicate instructions below)
☐ Other _____

CONTACT INFORMATION FOR CASE FOLLOW UP

Name: _____

Phone: _____ ext: _____

Fax: _____

E-mail: _____

SPECIAL INSTRUCTIONS

☐ Cover letter attached

☐ This is a Companion Case ☐ Issue w/Companion Policy # _____

☐ More than one application on same applicant _____ (Indicate Additional or Alternate Application)

☐ If approved other than applied for, do not issue until we have accepted offer

☐ At approval, hold for issue instructions

OTHER INFORMATION

Dr. Name/Contact Info: _____

Date/reason for last visit or significant health history: _____

Dr. Name/Contact Info: _____

Date/reason for last visit or significant health history: _____

OTHER SPECIAL INSTRUCTIONS

By providing complete and accurate information, processing time can be expedited.

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.

Rider & Benefit Reference Sheet

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

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

Universal Life Products	Houston Portfolio			Nashville Portfolio	
Rider/Benefit Name	**Elite UL [1]**	**AG Secure Lifetime GUL 3 [2]**	**AG Secure Survivor II [3]**	**QoL Guarantee Plus [2]**	**QoL Performer Plus [1]**
4 Year Term Rider			X		
Accidental Death Benefit	X	X		X	X
Additional Insurance Option					X
Additional Insured Rider[3]				X	X
Child Rider	X	X		X	X
Chronic Illness Rider (AAS)		X			
Defined Accelerated Benefit				X	X
DI Rider 2				X	
DI Rider 5				X	
Enhanced Surrender Value Rider		X	X		
Lifestyle Income Rider		X		X	
Monthly Guarantee Premium					X
Spouse/Other Ins Rider[3]	X	X			
Terminal Illness Rider	X	X			
Waiver of Monthly Deduction	X	X		X	X
Waiver of Monthly Guarantee Premium	X				
Waiver of Specified Premium					X

[1] Product requires a signed illustration. [2] Product requires a signed quotation. [3] This product and/or rider selection requires use of the Single or Multiple Insured(s) application.
Note: DO NOT submit this sheet with the application packet. For agent use only; not for dissemination to the public.

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Rider & Benefit Reference Sheet

Indexed Universal Life Products	Houston Portfolio					Nashville Portfolio
Rider/Benefit Name	**Elite Survivor Index II [3]**	**Elite Global Plus II [1]**	**Elite Global Survivor [3]**	**Elite Index II [1]**	**Value+ IUL [1]**	**QoL Index Plus II [1]**
4 Year Term Rider	X		X			
Accidental Death Benefit				X	X	X
Additional Insurance Option						X
Additional Insured Rider[3]						X
Child Rider				X	X	X
Chronic Illness Rider (AAS)				X	X	
Monthly Guarantee Premium						X
Spouse/Other Ins Rider[3]				X	X	
Surrender Value Enhancement Term Rider		X				
Terminal Illness Rider		X		X	X	
Waiver of Monthly Deduction		X		X	X	X
Waiver of Specified Premium						X

Variable Universal Life Products	Houston Portfolio
Rider/Benefit Name	**AG Platinum Choice VUL [1]**
20-Year Benefit Rider (20 Yr MGP Rider)	X
Accidental Death Benefit	X
Child Rider	X
Chronic Illness Rider (AAS)	X
Lapse Protection Benefit Rider (GMDB Rider)	X
Lifestyle Income Rider	
Spouse/Other Ins Rider[3]	X
Terminal Illness	X
Waiver of Monthly Deduction	X

[1] Product requires a signed illustration. [2] Product requires a signed quotation. [3] This product and/or rider selection requires use of the Single or Multiple Insured(s) application.
Note: DO NOT submit this sheet with the application packet. For agent use only; not for dissemination to the public.

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Individual Life Insurance Application
Single or Multiple Insured(s) - Part A

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** One World Financial Center, 200 Liberty St., New York, NY 10281
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. Other Proposed Insured

First Name _____ MI ___ Last Name _____ Gender ☐M ☐F
SSN _____ Birthplace* *(US State, or country)* _____ DOB _____ Current Age ____
Relationship to Primary Proposed Insured: _____
Tobacco Use Has the Other 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 Other 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

3. Owner - Complete if Primary Proposed Insured is not the Owner - *(If Owner is a business, charitable entity or trust, answer question 6 below.)*

First Name _____ MI ___ Last Name _____ Gender ☐M ☐F
SSN _____ DOB _____ Relationship to Proposed Insured _____
Driver's License ☐yes ☐no License State _____ Number _____

**for identification purposes only*

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 14.)

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

5. Beneficiary - *(If Beneficiary is a business, charitable entity or trust, answer question 6 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:				

6. 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 11E.)

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.) _____

7. 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 | Automatic Premium Loan**: ☐ yes ☐ no

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

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

☐ 4 Year Term
☐ 20-Year Benefit Rider
☐ Accidental Death & Dismemberment
☐ Accidental Death Benefit $_____
☐ Additional Insurance Option $_____
☐ Additional Insured $_____
☐ Child Rider[1] $ _____
  ☐ No current children
☐ Chronic Illness Rider (AAS)[2]
☐ Defined Accelerated Benefit
  ☐ Primary Proposed Insured
  ☐ 5% ☐ 10% ☐ Other _____
  ☐ Additional Proposed Insured
  ☐ 5% ☐ 10% ☐ Other _____
☐ Disability Income
  Monthly Benefit $ _____
  Occ Class _____

☐ DI Rider 2 | Monthly Benefit $ _____
☐ DI Rider 5 | Occ Class _____
  Applies to Primary ☐ and/or Spouse ☐
☐ Enhanced Surrender Value
☐ Lapse Protection Benefit Rider
☐ Level Term $_____
☐ Lifestyle Income[3]
  Withdrawal Benefit Basis % _____
☐ Monthly Guarantee Premium
☐ Select Income
  Monthly Benefit Amount $_____
  Benefit Duration _____
☐ Single Premium
  Whole Life $_____
☐ Spouse Level Term $ _____
☐ Spouse/Other Insured $_____

☐ Surrender Value
  Enhancement Term $ _____
☐ Terminal Illness
☐ Waiver of Monthly Deduction
☐ Waiver of Monthly
  Guarantee Premium
☐ Waiver of Premium
☐ Waiver of Specified
  Premium $ _____
☐ Other _____
  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.

***Complete only if applicable*

10. A. Information for an Additional Policy - *If more than one policy being applied for at this time please complete the section below.*

Individual to be insured is the ☐ Primary Proposed Insured or ☐ Other Proposed Insured listed on this application.

Plan Name _____ Term Duration** _____ Premium Class Quoted _____

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

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

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

Riders/Benefits

☐ 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 Rider/Benefit #1 $_____

Amount/Units _____

☐ Other Rider/Benefit #2 $_____

Amount/Units _____

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.

If beneficiary is to be other than as listed in question 5, please complete the following:

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:				

10. B. Information for an Additional Policy - *If more than one policy being applied for at this time please complete the section below.*

Individual to be insured is the ☐ Primary Proposed Insured or ☐ Other Proposed Insured listed on this application.

Plan Name _____ Term Duration** _____ Premium Class Quoted _____

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

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

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

Riders/Benefits

☐ 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 Rider/Benefit #1 $_____

Amount/Units _____

☐ Other Rider/Benefit #2 $_____

Amount/Units _____

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.

If beneficiary is to be other than as listed in question 5, please complete the following:

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:				

11. 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 applicable 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.

12. 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? ..... ☐ **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?	1035 Exchange?
1						☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ Amount of Coverage $ _____ Proposed Insured Name: _____						
2						☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ Amount of Coverage $ _____ Proposed Insured Name: _____						
3						☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ Amount of Coverage $ _____ Proposed Insured Name: _____						
4						☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ Amount of Coverage $ _____ Proposed Insured Name: _____						

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

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

	Primary Proposed Insured	Other Proposed Insured
A. Do any of the Proposed Insureds 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)* ..... Proposed Insured Name: _____ Details: _____	☐ yes ☐ no	☐ yes ☐ no
B. In the past five years, have any of the Proposed Insureds 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	☐ yes ☐ no
C. In the past five years, have any of the Proposed Insureds 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	☐ yes ☐ no
D. Have any of the Proposed Insureds ever had an application for insurance modified, rated, declined, postponed or withdrawn? *(If yes, list type of coverage, date and reason)* ..... Proposed Insured Name: _____ Details: _____	☐ yes ☐ no	☐ yes ☐ no
E. Have any of the Proposed Insureds 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)* ..... Proposed Insured Name: _____ Details: _____	☐ yes ☐ no	☐ yes ☐ no
F. In the past five years, have any of the Proposed Insureds pled guilty or been convicted of any driving violations to include driving under the influence of alcohol or drugs? *(If yes, list date, state, license #, and specific violation)* ..... Proposed Insured Name: _____ Details: _____	☐ yes ☐ no	☐ yes ☐ no
G. Have any of the Proposed Insureds ever been convicted of, or currently charged with, a felony or misdemeanor? *(If yes, list date, county, state, charge, current status and if currently incarcerated or on parole or probation.)* ..... Proposed Insured Name: _____ Details: _____	☐ yes ☐ no	☐ yes ☐ no
H. Are any of the Proposed Insureds 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)* ..... Proposed Insured Name: _____ Details: _____	☐ yes ☐ no	☐ 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 any of the Proposed Insureds as a result of this application?	☐ yes ☐ no	☐ yes ☐ no
J. Does the Owner or any of the Proposed Insureds intend to finance any of the premium required to pay for this policy through a financing or loan agreement?	☐ yes ☐ no	☐ yes ☐ no
K. Is the Owner, any of the Proposed Insureds, or any person or entity, being paid (cash, services, etc.) as an incentive to enter into this transaction? *(If yes, describe the incentive)* ..... Proposed Insured Name: _____ Details: _____	☐ yes ☐ no	☐ yes ☐ no

14. 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 or Other 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.

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) 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 other person or organization 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 or for such other period permitted by applicable state law where the policy is issued. 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 Proposed Insured Signature

X _____
(If under age 16 and coverage exceeds $500,000, signature of both parents required.)

AIG

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,** One World Financial Center, 200 Liberty St., New York, NY 10281
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.**

Elite Global Plus II

1-Year Index Cap Account _____% 5-Year Participation Rate Account _____%* Declared Interest Account _____%
**Not available in New York.*

Elite Global Survivor

1-Year Participation Rate Account _____% 5-Year Participation Rate Account _____%* Declared Interest Account _____%
**Not available in New York.*

Elite Index II

1-Year Index Cap Account _____% 1-Year Participation Rate Account _____% Declared Interest Account _____%

Elite Survivor Index II

1-Year Index Cap Account _____% 1-Year Participation Rate Account _____% Declared Interest Account _____%

QoL Index Plus II

1-Year Index Cap Account _____% 1-Year Participation Rate Account _____% Declared Interest Account _____%

Value+ IUL

1-Year Index Cap Account _____% 1-Year Participation Rate Account _____% 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.

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,** One World Financial Center, 200 Liberty St., New York, NY 10281
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.)*

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:				%
				%
				%
				%
				%

12. 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 # _____

AIG

Summary And Disclosure Notice For Accelerated Benefits

American General Life Insurance Company, American General Center, Nashville, Tennessee 37250-0001
A member of American International Group, Inc. (AIG)

Receipt of a benefit under the Accelerated Death Benefit Rider (Accelerated Benefit Rider) will reduce any death benefit that may become payable under the policy to which the rider is attached.

PURPOSE OF THIS SUMMARY AND DISCLOSURE

THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE ACCELERATED BENEFIT RIDER BEING APPLIED FOR. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE RIDER.

If a policy is issued, it is important to check the policy for details on the Accelerated Death Benefit Rider that is included in the policy and to check the Insured Person(s) covered under the rider. It is also important to carefully read any Accelerated Benefit Rider included in the policy.

TAX CONSEQUENCES

Benefits paid under the Accelerated Death Benefit Rider may cause the Owner to incur a tax obligation. Neither the Company nor its agents are authorized to offer you tax advice. You should consult your accountant, attorney or other qualified tax professional to assess the impact of a benefit.

BENEFIT DESCRIPTIONS

Accelerated benefit means the payment, during the Insured Person's lifetime, of a portion of the Insured Person's death benefit under the policy. An Accelerated Benefit Rider provides that the Owner may receive an accelerated benefit if the Insured Person experiences a covered Qualifying Event, subject to the provisions of the rider. Qualifying Event means a Qualifying Critical Illness, Qualifying Chronic Illness or Qualifying Terminal Illness (as defined below) that is diagnosed or certified while the policy is in force.

The rider is designed to provide two types of accelerated benefits, a Defined Accelerated Benefit and a Flexible Accelerated Benefit: The Defined Accelerated Benefit is an optional benefit which provides for payment of a predetermined portion of the death benefit upon the occurrence of a Qualifying Event. The Defined Accelerated Benefit for the initial Qualifying Event is determined as a fixed percentage of the maximum death benefit that can be accelerated under the policy. The Defined Accelerated Benefit for a subsequent Qualifying Event is calculated using a reduced percentage of the initial percentage. The Flexible Accelerated Benefit provides for acceleration of all or a portion of the remaining death benefit that may be accelerated after any Defined Accelerated Benefit is paid. Any portion of the death benefit that is elected to be accelerated as a Flexible Accelerated Benefit is subject to an actuarial discount.

Below are general descriptions of the Qualifying Events under the Accelerated Benefit Rider. Limitations and conditions apply, so you should refer to your policy for details.

Qualifying Terminal Illness means an illness or physical condition:

(a) for which an Insured Person is diagnosed and certified by a physician as being reasonably expected to result in such Insured Person's death within 24 months from the date of diagnosis; and

(b) which is diagnosed and certified by a physician after an Insured Person's coverage under the rider is in force.

Qualifying Chronic Illness means an illness or physical condition:

(a) for which an Insured Person was certified as having by a licensed health care practitioner not more than 12 months before the date of our receipt of such certification; and

(b) for which an Insured Person was certified as having by a licensed health care practitioner after such Insured Person's coverage under the Rider has been in force for 30 consecutive days; and

(c) which permanently affects the Insured Person so that he or she is:

  (1) unable to perform, without substantial assistance from another person, at least two Activities Of Daily Living due to a loss of functional capacity; or

  (2) requires substantial supervision by another person to protect him or her from threats to health and safety due to permanent Severe Cognitive Impairment; and

(d) for which the Insured Person is under a plan of care prescribed by a licensed health care practitioner; and

(e) which is not caused by a mental or nervous disorder (except for disorders comparable to Alzheimer's disease and similar forms of irreversible dementia), and alcoholism or drug addiction; and

(f) which is not a Qualifying Terminal Illness.

BENEFIT DESCRIPTIONS (CON'T)

The Activities Of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the Insured Person's:

(a) short-term or long-term memory;

(b) orientation to people, places or time; and

(c) deductive or abstract reasoning.

Qualifying Critical Illness means any of the following illnesses or conditions - Major Heart Attack, Stroke, Coronary Artery Bypass, Invasive Cancer, End Stage Renal Failure, Major Organ Transplant, Paralysis, Coma and Severe Burn:

(a) for which an Insured Person was certified as having by a physician not more than 12 months before the date of our receipt of such certification; and

(b) for which an Insured Person is diagnosed as having by a physician after such Insured Person's coverage under the Rider has been in force for 30 consecutive days, or 90 consecutive days for invasive cancer; and

(c) which is not a Qualifying Chronic Illness or Qualifying Terminal Illness.

BENEFIT AMOUNT

The benefit payable under the Accelerated Benefit Rider is paid as a lump sum on the benefit payment date and is equal to the portion of the death benefit that the Owner elects to accelerate, subject to the following deductions:

(a) if applicable, the actuarial discount applicable to the elected death benefit;

(b) an administrative charge;

(c) payment of any unpaid but due policy premiums; and

(d) if applicable, payment of a pro rata amount of any policy loans.

As a result of these deductions, any benefit paid will, in all cases, be less than the portion of the death benefit that the Owner elects to accelerate, and may be substantially less.

The benefit paid will never be less than the cash surrender value, if any, which corresponds to the portion of the death benefit that the Owner elects to accelerate.

If a benefit under an Accelerated Benefit Rider is payable and the Owner elects to receive such benefit, the Company will provide the Owner with one (1) opportunity to elect a Flexible Accelerated Benefit and/or a Defined Accelerated Benefit, if applicable, under the Policy as to such Qualifying Event. To make such an election, the Owner must complete an election form and return it to AGL within 60 days of receipt of the election form. The Company will not provide a later opportunity to elect a Flexible Accelerated Benefit and/or a Defined Accelerated Benefit, if applicable, under a Policy as to the same Qualifying Critical Illness or Qualifying Chronic Illness. Under certain circumstances where an insured's mortality (i.e., our expectation of the insured's life expectancy) is not significantly changed by a Qualifying Critical Illness or Qualifying Chronic Illness, the accelerated benefit may be zero.

The maximum amount of life insurance death benefits as to an Insured Person that may be accelerated during his or her lifetime under all accelerated benefit riders of all kinds is the lesser of the aggregate amount of such death benefits or a lifetime maximum amount of $1,500,000.

EFFECT OF BENEFIT PAYMENT ON POLICY

The following adjustments are made upon payment of an accelerated benefit for an Insured Person:

(a) the Insured Person's death benefit under the policy is reduced by the Defined Accelerated Benefit paid, if any, and the portion of the Insured Person's death benefit the Owner accelerates as a Flexible Accelerated Benefit;

(b) the face amount or specified amount of the Insured Person's life insurance coverage under the policy is reduced in the same proportion as the reduction in the Insured Person's death benefit;

(c) if applicable, the accumulation value, cash surrender value, cash value, and any policy loan are reduced in the same proportion as the reduction in the Insured Person's death benefit; and

(d) the premium and charges for the Insured Person's life insurance coverage under the policy are set as if such coverage had been originally issued at the reduced coverage amount.

The Insured Person's life insurance coverage under the policy will terminate on a benefit payment date if the face amount or specified amount, as applicable, for such Insured Person's life insurance coverage under the policy is reduced to zero on such date due to a benefit payment made under the rider.

GENERIC NUMERICAL ILLUSTRATION

The following is a generic, hypothetical illustration demonstrating the effect of payment of an accelerated benefit on the values of the policy to which the rider is attached. The hypothetical example shown assumes that $25,000 is being accelerated. This hypothetical illustration makes no representation about the amount of any accelerated benefit that might be payable due to the acceleration of death benefit.

Policy Values	Prior to Payment of Accelerated Benefit	After Payment of Accelerated Benefit
Specified Amount/Face Amount	$100,000	$75,000
Death Benefit	$100,000	$75,000
Accumulation Value, if applicable	$30,000	$22,500
Policy Loan Balance	$2,000	$1,500
Cash Surrender Value	$28,000	$21,000
Annual Premium (example assumes premium includes a $100 annual policy fee)	$1,000	$775

LIMITATIONS

The Owner is not eligible to claim a benefit under the Accelerated Benefit Rider if:

(a) the Owner is required by law to use this rider to meet the claims of creditors, whether in bankruptcy or otherwise;

(b) the Owner is required by a government agency to use the rider to apply for, obtain or keep a government benefit or entitlement;

(c) the Owner is required by a court order to maintain such Insured Person's life insurance coverage under the policy and any covered riders for another person's benefit;

(d) any qualifying chronic illness, any qualifying critical illness or any qualifying terminal illness results directly from the Insured Person's self-inflicted injury or attempted suicide, while sane or insane; or

(e) the consent of any irrevocable beneficiary, assignee or other required party to the Owner's election of an accelerated benefit has not been obtained; or

(f) receipt of such benefit would cause the policy to fail to qualify as life insurance under applicable tax laws.

MEDICAID/GOVERNMENT BENEFITS

Receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

PREMIUMS OR COST OF INSURANCE

There will be a premium or charge for the rider if it provides for Defined Accelerated Benefits. The premium or monthly cost of insurance for the rider is shown in the policy. Premiums for the rider are payable in addition to and under the same conditions as premiums for the policy. If applicable, the cost of insurance for the rider will be included in the monthly deduction from the policy accumulation value while the rider is in force.

IMPORTANT NOTICE

Any portion of the death benefit that is elected to be accelerated as a Flexible Accelerated Benefit is subject to an actuarial discount. The actual benefit payable as a Flexible Accelerated Benefit for any given occurrence of a qualifying event will not be known until the time of claim. The benefit payable will vary depending on the Company's assessment of the Insured Person's expected future mortality at the time of claim as well as other factors used in calculating the benefit and may, under certain circumstances, be zero.

To assist you in making a decision about electing a Flexible Accelerated Benefit under the rider, a statement showing the amount of benefit payable, if any, and the effect that the election of a Flexible Accelerated Benefit will have on your policy will be sent to you once the Company has determined that a Qualifying Event or Subsequent Qualifying Event has occurred.

IMPORTANT CONSUMER DISCLOSURES REGARDING ACCELERATED BENEFIT RIDER

(1) When filing a claim for Qualifying Critical Illness, Qualifying Terminal Illness or Qualifying Chronic Illness under an Accelerated Benefit Rider, the claimant must provide to the Company a completed claim form (with Certification attached in the case of a Qualifying Chronic Illness) which must be received at its Administrative Center within the time frame specified in the Rider, if any.

(2) If a benefit under an Accelerated Benefit Rider is payable and the Owner elects to receive such benefit, the Company will provide the Owner with one (1) opportunity to elect a Flexible Accelerated Benefit and/or a Defined Accelerated Benefit, if applicable, under the Policy as to such Qualifying Event. To make such an election, the Owner must complete an election form and return it to AGL within 60 days of receipt of the election form. The Company will not provide a later opportunity to elect a Flexible Accelerated Benefit and/or a Defined Accelerated Benefit, if applicable, under a Policy as to the same Qualifying Critical Illness or Qualifying Chronic Illness. Under certain circumstances where an insured's mortality (i.e., our expectation of the insured's life expectancy) is not significantly changed by a Qualifying Critical Illness or Qualifying Chronic Illness, the accelerated benefit may be zero.

(3) The failure to provide a required claim form and a required election form (with the requested attachments) within the periods set forth for each in a Policy may preclude payment of a benefit.

(4) Benefits payable under an accelerated benefit rider may be taxable. Neither American General Life Insurance Company nor any agent representing it is authorized to give legal or tax advice. Please consult a qualified legal or tax advisor regarding questions concerning the information and concepts contained in this material.

(5) Generally, we will send you an IRS Form 1099-LTC if you receive an accelerated death benefit on account of a Chronic Illness or a Terminal Illness. We will send you an IRS Form 1099-R if you receive an accelerated death benefit on account of a Critical Illness.

The sum that will be included in Box 2 (Accelerated death benefits paid) of IRS Form 1099-LTC or in Box 1 (Gross distribution) of IRS Form 1099-R will be the actual sum you received by check or otherwise minus any refund of premium and/or loan interest included with our benefit payment plus any unpaid but due policy premium, if applicable, and/or pro rata amount of any loan balance.

(6) The maximum amount of life insurance death benefits that may be accelerated as to an Insured Person under all accelerated benefit riders is the lesser of the existing amount of such death benefits or a lifetime maximum of $1,500,000.

(7) See your policy for details.

NOTICE REGARDING SUBSTITUTION OF QOL SELECTCHOICE ACCELERATED BENEFIT RIDER (I.E., ACCELERATED BENEFIT RIDER DESCRIBED ABOVE) FOR EXISTING NO-COST ACCELERATED BENEFIT RIDERS

If I am applying to substitute an QoL SelectChoice Accelerated Benefit Rider with a Defined Accelerated Benefit for the existing no-cost accelerated benefit riders on the policy noted above, I acknowledge that I have carefully compared (or have had the opportunity to carefully compare) the benefits of my existing no- cost accelerated benefit riders and the benefits of the QoL SelectChoice Accelerated Benefit Rider with a Defined Accelerated Benefit for which I am applying. I also acknowledge that I am aware that there will be a premium charge for the QoL SelectChoice Accelerated Benefit Rider with Defined Accelerated Benefit. I further acknowledge:

(a) that some or all of the benefits under the existing no-cost accelerated benefit riders on the policy noted above differ from those in the new rider;

(b) that some or all of the benefits under the existing no-cost accelerated benefit riders on the policy noted above may be more advantageous to me than those under the applied-for rider;

(c) that some of benefits under the new QoL SelectChoice Accelerated Benefit Rider with Defined Accelerated Benefit may be more advantageous to me than those under existing no-cost accelerated benefit riders on the policy noted above; and

(d) that the applied-for rider may exclude coverage for claims arising from conditions for which the existing no-cost accelerated benefit riders on the policy noted above may provide coverage.

ACKNOWLEDGMENT

I acknowledge that I have reviewed this Summary and Disclosure and have received a copy of it or will be provided a copy with my policy.

Owner's Signature

X _____

Owner signed on (date) _____

The applicant was shown a copy of this Summary and Disclosure prior to executing an application.

Agent's Signature

X _____

Agent signed on (date) _____

Notice and Consent Form For AIDS Virus (HIV) Antibody/Antigen Testing

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, One World Financial Center, 200 Liberty St., New York, NY 10281
A member of American International Group, Inc. (AIG)

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions will be based on the test results.

PRE-TESTING CONSIDERATION

Many public health organizations have recommended that before taking an AIDS virus (HIV) antibody/antigen test a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. The results also may be reported to the following:

1. persons who have the responsibility to make underwriting decisions on behalf of the insurer;
2. a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality; and
3. the insurer's affiliates or legal counsel who needs such information to effectively represent the insurer in regard to matters concerning the proposed insured.

All the persons and organizations named above may have access to your insurance file. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.). Results of the tests will not otherwise be disclosed except as required or allowed by law. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

MEANING OF POSITIVE TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at increased risk of developing AIDS or AIDS-related conditions. The tests are tests for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus.

Positive HIV antibody/antigen test results will adv--ersely affect your application for insurance. This means that your application will probably be declined.

Name and address of physician for reporting a positive test result:

Name: _____

Address _____

_____

CONSENT

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. 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.

Proposed Insured's or Parent/Guardian's Signature

X _____

Proposed Insured's name (printed) _____

_____

Signed on (date) _____

AIG

HIPAA Authorization

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

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the 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 _____

_____

Notice Regarding Replacement
New Jersey 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, One World Financial Center, 200 Liberty St., New York, NY 10281
A member of American International Group, Inc. (AIG)

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed purchase* occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

Are You Replacing Coverage? We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

Applicant's and Producer's Non-Replacement Certification. Having answered "no" to questions 1 and 2, no replacement of coverage is occurring. We certify that the above two responses are, to the best of our knowledge, accurate.

Applicant's Signature

X _____

Applicant signed on (date) _____

Applicant's name (printed) _____

Producer's Signature

X _____

Producer signed on (date) _____

Producer's name (printed) _____

If signed above, do not complete the remainder of the form.
If you answered "yes" to either question 1 or 2, complete the remainder of this form, as directed.

List each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its producer for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

Reason for Replacement: The existing policy or contract is being replaced because _____

_____.

Sales Materials. A copy of all printed sales materials used in connection with this transaction must be provided to the applicant. In addition, the producer should attach to the application all individualized sales materials used and list below all other sales materials used. *(List form number and brief description or name of sales materials used. If no sales materials were used, indicate "None".)*

_____

_____

Replacement Factors. A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as the sole basis to compare policies or contracts. You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

Applicant's Certification. I certify that the responses in this document are, to the best of my knowledge, accurate. I recognize that, for a period of 30 days from the date I receive my new policy or contract, I have the right to return it for an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract.

Applicant's Signature

X _____ _____ _____

Applicant's name (printed) **Date**

Producer's Certification. I certify that the responses in this document are, to the best of my knowledge, accurate and that this replacement transaction is in accord with the Company's replacement guidelines with respect to the acceptability and appropriateness of such transactions.

X_____ _____ _____

Producer's Signature **Producer's name** (printed) **Date**

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,** One World Financial Center, 200 Liberty St., New York, NY 10281

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)

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.**

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_____

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.

Premium Payor Authorization
New Business

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** One World Financial Center, 200 Liberty St., New York, NY 10281

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.

Directions: Complete this form when (1) the Payor is different from the Insured or the Owner AND (2) Bank Draft or Credit Card is not the chosen method of payment.

A. Premium Payor Designation

First Name _____ MI _____ Last Name _____

SSN or Tax ID # _____

B. Insurance Policy Information

Policy Number, if available	Name of Insured/Applicant

C. Agreement and Authorization

I request that I be made the Premium Payor for the policy(ies) shown above. I certify that all of the information provided herein is true and accurate. I agree to hold the Company harmless from any and all costs, claims, or causes of actions arising from or related to this authorization. I further authorize the Company or its representative 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 consistent with applicable law.

Premium Payor Signature

X

Signed on (date) _____

AIG

QoL Advantage Form

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,** One World Financial Center, 200 Liberty St., New York, NY 10281
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. For Any Associated Plan or Stand-alone Policy:

   a. Name of Proposed Insured _____
   Plan _____
   Policy number or name of insured on the qualified policy if the application is pending _____
   Please check which of the following applies:
   - ☐ FT1 Same Insured, Same Owner, Same Billing, Applied for at Same Time
   - ☐ FT2 Same Insured, Same Owner, Same Billing, Applied for at a Later Date
   - ☐ FT3 Same Owner, Different Billing
   - ☐ FT2 Different Insured, Same Owner, Same Billing
   - ☐ FT3 Different Owner
   - ☐ FT4 Stand-alone Policy

   b. Name of Proposed Insured _____
   Plan _____
   Policy number or name of insured on the qualified policy if the application is pending _____
   Please check which of the following applies:
   - ☐ FT1 Same Insured, Same Owner, Same Billing, Applied for at Same Time
   - ☐ FT2 Same Insured, Same Owner, Same Billing, Applied for at a Later Date
   - ☐ FT3 Same Owner, Different Billing
   - ☐ FT2 Different Insured, Same Owner, Same Billing
   - ☐ FT3 Different Owner
   - ☐ FT4 Stand-alone Policy

   c. Name of Proposed Insured _____
   Plan _____
   Policy number or name of insured on the qualified policy if the application is pending _____
   Please check which of the following applies:
   - ☐ FT1 Same Insured, Same Owner, Same Billing, Applied for at Same Time
   - ☐ FT2 Same Insured, Same Owner, Same Billing, Applied for at a Later Date
   - ☐ FT3 Same Owner, Different Billing
   - ☐ FT2 Different Insured, Same Owner, Same Billing
   - ☐ FT3 Different Owner
   - ☐ FT4 Stand-alone Policy

   d. Name of Proposed Insured _____
   Plan _____
   Policy number or name of insured on the qualified policy if the application is pending _____
   Please check which of the following applies:
   - ☐ FT1 Same Insured, Same Owner, Same Billing, Applied for at Same Time
   - ☐ FT2 Same Insured, Same Owner, Same Billing, Applied for at a Later Date
   - ☐ FT3 Same Owner, Different Billing
   - ☐ FT2 Different Insured, Same Owner, Same Billing
   - ☐ FT3 Different Owner
   - ☐ FT4 Stand-alone Policy

2. **Agent Agreement and Signature**
   I certify that the above information is true and complete to the best of my knowledge and belief.
   Writing Agent Name (Please print) _____ Date _____
   Writing Agent Name Signature _____
   State License #_____ Phone # _____
   Email_____ Fax #_____

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. Has any Proposed Insured ever been diagnosed with, or sought treatment from a member of the medical profession for any of the following: a heart attack; stroke; coronary artery disease or other heart disease; cancer; diabetes; or disorder of the immune system, including but not limited to Acquired Immune Deficiency Syndrome (AIDS) or infection by the Human Immunodeficiency Virus (HIV)?	☐	☐
b. 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 or surgery not yet performed (except for those tests related to the Human Immunodeficiency Virus (HIV))?	☐	☐
c. 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 $500,000, 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.

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

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P.O. Box 1931
Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

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: 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.

Request For Policy Illustration

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, One World Financial Center, 200 Liberty St., New York, NY 10281
A member of American International Group, Inc. (AIG)

Proposed Insured: _____

APPLICANT'S STATEMENT:

I acknowledge that no illustration conforming to the policy applied for was provided at the time of application. I understand that an illustration conforming to the policy as issued will be provided to me at the time of policy delivery.

Proposed Owner's Signature

X _____

Proposed Owner signed on (date) _____

AGENT'S STATEMENT:

I certify that no illustration conforming to the policy applied for was used during the application process.

Agent's Signature

X _____

Agent signed on (date) _____

Local Office _____

Agency _____

Request for Policy Quotation

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, One World Financial Center, 200 Liberty St., New York, NY 10281
A member of American International Group, Inc. (AIG)

Proposed Insured: _____

APPLICANT'S STATEMENT:

I acknowledge that no quotation conforming to the policy applied for was provided at the time of application. I understand that a quotation conforming to the policy as issued will be provided to me at the time of policy delivery. I have been advised to consult with my own tax or legal advisors regarding the tax effects of the proposed coverage. I further understand that the guarantees provided are directly affected by the amount and timing of premiums paid.

Proposed Owner's Signature

X _____

Proposed Owner signed on (date) _____

AGENT'S STATEMENT:

I certify that no quotation conforming to the policy applied for was used during the application process. I certify that I have explained that the owner should consult with his or her own tax or legal advisors regarding the tax effects of the proposed coverage.

Agent's Signature

X _____

Agent signed on (date) _____

Local Office _____

Agency _____

AIG

Child Rider Supplement

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,** One World Financial Center, 200 Liberty St., New York, NY 10281
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 *(parent or legal guardian)*

First Name	MI	Last Name	Date of Birth	Social Security #

1. **Total number of current children for whom application is being made:** _____
(Eligible child(ren) include: child, step-child, legally adopted child of the proposed insured. If more than 5 children to be insured please complete additional Child Rider Supplements and indicate total number of children being insured here.)

2. **Child(ren) proposed for coverage under the Children's Insurance Benefit Rider**

	Name: First, Middle Initial, Last	Age	Date of Birth	Gender	Height	Weight	Birth Weight (if less than 1 year old)
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							

	Give details to all yes answers in Remarks, including all dates and diagnosis.	Child 1	Child 2	Child 3	Child 4	Child 5
3.	Has any child proposed for coverage ever been diagnosed as having, been treated for, or consulted a licensed health care provider for Attention Deficit Hyperactivity Disorder (ADHD), Congenital Heart Abnormalities, Heart Disorder, Epilepsy, Cancer, Leukemia, Diabetes, Cystic Fibrosis, Kidney Disease, Brain, Psychiatric or Neurological Disorder, Asthma or Lung Disease?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.	Within the last 5 years has any child proposed for coverage been treated or diagnosed by a member of the medical profession for any other condition that is not disclosed above?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

5. Remarks *(Give details to all yes answers, including Child #, Question #, physician information, all dates, diagnosis, and/or treatments)*

_____

_____

_____

_____

_____

_____

_____

6. **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 any child proposed for coverage 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

B. If question 6A 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 $ _____ Child's Name: _____						
2						☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ Amount of Coverage $ _____ Child's Name: _____						
3						☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ Amount of Coverage $ _____ Child's Name: _____						
4						☐ Y ☐ N	☐ Y ☐ N
	Company Name: _____ Amount of Coverage $ _____ Child's Name: _____						

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

Agreement: I agree that: (1) I have read the statements and answers contained in this Supplement, or they have been read to me; (2) They are true and complete to the best of my knowledge and belief; and (3) This Supplement shall be a part of the Application for life insurance for the Primary Proposed Insured listed above. As the Parent or Guardian of the child(ren) proposed for coverage, I agree that I have read the Authorization to Obtain and Disclose Information in Part A or it has been read to me. By signing below, I hereby consent to such authorization for the child(ren) proposed for coverage. I also attest that I have the legal right to apply for coverage on the child(ren) proposed for coverage.

Owner Signature *(same Owner shown on the application)*

X _____

Owner signed on (date) _____

Custodial Parent or Legal Guardian of any child(ren) proposed for coverage Signature *(if other than Owner)*

X _____

Custodial Parent or Legal Guardian signed on (date)_____

AIG

Absolute Assignment

American General Life Insurance Company (the "Company")

To Effect Section 1035 Exchange and Rollover of a Life Insurance Policy or Annuity Contract

Policy/Contract No. _____ Cash Value _____

Owner _____ Insured _____

Insurer _____

Contract Statement:

☐ CONTRACT INCLUDED *If contract is not lost, please submit with this form.*

☐ CERTIFICATE OF LOST CONTRACT

I certify that the above numbered contract has been lost or destroyed and to the best of my knowledge and belief, is not in anyone's possession.

I hereby assign and transfer from Insurer to (new company) _____ (the "Company") all rights, title and interest of every nature and transfer to character in and to the Policy/Contract described above ("the Policy") in an exchange intended to qualify under Section 1035 of the Internal Revenue Code.

I understand that if the Company underwrites, approves my application for, and issues to me a new life insurance policy or annuity contract which I accept on the life of the same insured/annuitant in the Policy, then the Company intends to surrender the Policy for its cash value.

I understand that as of the date of surrender of the Policy by the Company, the Policy will no longer provide any coverage.

I understand that upon receipt of the surrender value by the Company, the proceeds will be applied as an additional premium for the new life insurance policy or annuity contract. The first premium must be paid no later than when the new policy or contract is delivered. The Policy assigned shall not be considered a premium until the cash surrender value is actually received by the Company. There will be no policy or contract in effect unless the first premium is paid while all statements and answers in all parts of my application remain correct.

I understand that by executing this assignment, I irrevocably waive all rights, claims and demands under the Policy.

I represent and agree that the Company is furnishing this form and is participating in this transaction at my specific request and as an accommodation to me. I represent and agree that the Company has made no representations concerning my tax treatment under Internal Revenue Code Section 1035 or otherwise.

The Company assumes no responsibility or liability for the undersigned's tax treatment under Internal Revenue Code Section 1035 or otherwise.

I represent and warrant that no person, firm or corporation has a legal or equitable interest in the Policy, except the undersigned, and that no proceedings of either a legal or equitable nature have been instituted or are pending against undersigned.

I understand that the first premium must be paid no later than the time the Policy or contract applied for is delivered and that the cash value of the assigned Policy shall not be considered part of the premium until the cash surrender value is actually received by the Company. I further understand that no policy or contract comes into force as a result of this assignment.

Owner Signature (Assignor)

X _____

Signed at (city, state) _____

Date _____

Witness _____

Co-Owner / Spouse / Irrevocable Beneficiary (if required)

X _____

Signed at (city, state) _____

Date _____

For American General Home Office use only:

Company name _____

By company representative _____ Address _____

Title _____ City/State/Zip _____