Quality of Life...Insurance®

Your Money. Your Insurance. Your Choice.

Life Kit

NEW JERSEY

Changing the Way Americans Think About, Purchase and Use Life Insurance.®

American General Life Insurance Company
American General Center
Nashville, TN 37250-0001

Checklist for New Business Paper Applications

Providing complete and accurate information on and with the application will allow a fairer and prompt decision. Use this Checklist to make sure everything needed for the new application package is included.

- ☐ Application form used is approved in state written.
- ☐ Privacy Act Authorization Form 2118A, if required in your state.
- ☐ HIPAA Authorization
  2119 – New Business Life
  2120 – New Business Health
- ☐ Carefully ask and record the answers to all applicable questions on the application. For any proposed insured who will be medically examined, the health questions may be omitted. If CTR applied, all health questions must be answered. If the medical exam requirement is satisfied from a recently processed application, all health questions are required to be answered to update the health history.
- ☐ Review application and all forms for accuracy and completeness.
- ☐ 9051 - Cancer Disclosure of Replacement required on all cancer applications which are replacing existing cancer insurance.
- ☐ HIV Consent Form must be signed before or on same date as the application, if required by your state.
- ☐ All required signatures on application and associated forms.
- ☐ Voided Check and 1021A form if ABC is desired.
- ☐ Illustration with required signature (Interest Sensitive Products).
- ☐ State-required Replacement Forms.
- ☐ Financial Questionnaire required on **all** Business cases regardless of amount and all Individual applications over $1,000,000 for ages 18-70 and over $249,999 for 71+. Submit a copy of the most recent balance sheet and income statement on Business Insurance applications.
- ☐ Cover letter on applications of $500,000 and above always helpful to underwriter.
- ☐ If application on juvenile, review Rate Manual for amount restrictions and ownership.
- ☐ If medical required, advise Paramedical Examiner you are an AGLA agent and application will be underwritten in Nashville. Make sure applicant advised to fast at least 8 hours prior to blood drawn.
- ☐ Give copy of the “Notice of Information Practices” to Proposed Insured at the time of application.
- ☐ Arbitration form must be signed by Owner with same date as application in AL and MS only.
- ☐ It is suggested that you not quote a premium class better than Standard Plus (Term) or Standard (Permanent).
- ☐ Give complete occupation duties and sources of income.

AGLA2183 REV0114

APPLICATION FOR LIFE INSURANCE

American General Life Insurance Company
American General Center • Nashville, Tennessee 37250-0001
Home Office - Houston, TX

1. a. Primary Proposed Insured Name (Print full name) _____

b. Address _____
Street City State Zip Code Country

Birth Date and Place (Month, Day, Year, State, Country) | Age | Gender ☐ Male ☐ Female

c. SSN: _____

d. Marital/Domestic Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

e. Driver's License No. _____ f. State of Issue _____

If over age 16 and no license, please explain. _____

g. Annual Earned Income _____ h. Other Sources of Income _____

i. Occupation _____ j. How long in occupation _____

k. Employer _____ l. Job duties _____

m. Length of time employed by current employer _____ n. Average No. of hours worked per week in occupation _____

o. Is Primary Proposed Insured actively at work and able to perform all regular job duties? ☐ Yes ☐ No

If "No," explain: _____

p. If no earned income, provide details of prior employment and job duties _____

q. If unemployed, retired prior to age 55, disabled or receiving Supplemental Security Income (SSI), provide explanation _____

_____

2. a. Additional Proposed Insured (If coverage applied for) _____

b. Address _____
Street City State Zip Code Country

Birth Date and Place (Month, Day, Year, State, Country) | Age | Gender ☐ Male ☐ Female

c. SSN: _____

d. Marital/Domestic Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

e. Driver's License No. _____ f. State of Issue _____

If over age 16 and no license, please explain. _____

g. Annual Earned Income _____ h. Other Sources of Income _____

i. Occupation _____ j. How long in occupation _____

k. Employer _____ l. Job duties _____

m. Length of time employed by current employer _____ n. Average No. of hours worked per week in occupation _____

o. Is Additional Proposed Insured actively at work and able to perform all regular job duties? ☐ Yes ☐ No

If "No," explain: _____

p. If no earned income, provide details of prior employment and job duties _____

q. If unemployed, retired prior to age 55, disabled or receiving Supplemental Security Income (SSI), provide explanation _____

_____

3. Enter names of children, stepchildren and legally adopted children for whom application for coverage under a Child Term Rider is made who are: (1) members of your immediate family and household; and (2) under the age of 18.

	Full Name	Age	Birth Date Month	Day	Year	Gender	Relationship (If stepchild, consent required)
a.							
b.							
c.							
d.							

For any child under age one (including Primary Proposed Insured)
Name: _____
Birth Weight ____ lbs. ____oz.
Weight Now ____ lbs. ____oz.

4. Owner Name (If other than Primary Proposed Insured) _____

Address _____
Street City State Zip Code

SSN/TIN: _____ Relationship to Primary Proposed Insured _____

Office Use Only

5. Premium Payor Name (If other than Primary Proposed Insured) _____

Address _____
Street City State Zip Code

SSN/TIN: _____ Relationship to Primary Proposed Insured _____

6. Complete for Primary Proposed Insured:

a. Plan Name _____ If Term: Duration _____ Ins Amount $ _____

If Universal Life: Death Benefit ☐ Option A ☐ Option B

For Indexed UL Only: Initial Premium Allocation Percentages

(Must Total 100%) Index Cap Account _____% Participation Rate Account _____% Declared Interest Account _____%

b. Benefits & Riders

☐ Lifestyle Income Rider
Initial Withdrawal Benefit Basis _____ %

☐ Premium Waiver Rider (Term, WL)

☐ Waiver of Monthly Deduction Rider (UL)

☐ Additional Insurance Option $ _____

☐ Accidental Death $ _____

☐ Single Premium Whole Life $ _____

☐ Spouse Level Term Rider $ _____ Amt

☐ Terminal Illness Rider

☐ Waiver of Specified Premium Rider (IUL, GUL, UL)

☐ Monthly Guarantee Premium Rider

☐ Children's Term Rider $ _____ Amt

☐ Level Term Rider $ _____ Amt

☐ Additional Insured Rider $ _____ Amt

☐ Accelerated Benefit Rider 2 Initial Defined Benefit – Primary Proposed Insured ☐ 5% ☐ 10% ☐ Other _____

☐ Accelerated Benefit Rider 2 Initial Defined Benefit – Additional Proposed Insured ☐ 5% ☐ 10% ☐ Other _____

☐ Primary Proposed Insured
- ☐ Disability Income Rider 2
- ☐ Disability Income Rider 5

Monthly Benefit _____
Occ. Class _____

☐ Other _____

☐ Additional Proposed Insured
- ☐ Disability Income Rider 2
- ☐ Disability Income Rider 5

Monthly Benefit _____
Occ. Class _____

☐ Other _____

7. First Beneficiary _____
Name Relationship Age SSN/TIN

_____
Address

Secondary Beneficiary _____
Name Relationship Age SSN/TIN

_____
Address

8. Premium and Payment

a. Premium $_____ Lump Sum _____ ☐ 1035 exchange

b. Payment Mode: ☐ A ☐ S ☐ Q ☐ M Planned Periodic Premium _____

☐ Other _____

☐ Automatic Bank Check
☐ AG Payroll Deduction (AGLA employees only)
☐ Payroll Deduction

☐ Add to existing ABC account, policy no. _____
☐ New payroll account no. _____
☐ Add to existing PD account no. _____
Anticipated Effective Date of Coverage _____

If premium mode is payroll deduction, are premiums to be paid with pre-tax dollars under a Section 125 (cafeteria plan sponsored by your employer)?
☐ Yes ☐ No

c. If Available, is Automatic Premium Loan Provision to be in effect? ☐ Yes ☐ No

If one or more policies are being applied for at this time having the same Owner and Premium Mode/Method, please complete the section(s) below:

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

b. Plan Name_____ If Term: Duration _____ Ins Amount $_____ If UL: Death Benefit ☐ Option A ☐ Option B

c. Benefits & Riders
☐ Waiver Rider
☐ Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 9.a. ☐ 5% ☐ 10% ☐ Other _____
☐ Other _____ ☐ Other _____

d. If beneficiary is to be other than as listed in question 7 above, please complete the following:

First Beneficiary _____
Name Relationship Age SSN/TIN

_____
Address

Secondary Beneficiary _____
Name Relationship Age SSN/TIN

_____
Address

e. Premium $ _____ ☐ Lump Sum _____ ☐ 1035 exchange ☐ Planned Periodic Premium _____

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

b. Plan Name_____ If Term: Duration _____ Ins Amount $_____ If UL: Death Benefit ☐ Option A ☐ Option B

c. Benefits & Riders
☐ Waiver Rider
☐ Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 10.a. ☐ 5% ☐ 10% ☐ Other _____
☐ Other _____ ☐ Other _____

d. If beneficiary is to be other than as listed in question 7 above, please complete the following:

First Beneficiary _____
Name Relationship Age SSN/TIN

_____
Address

Secondary Beneficiary _____
Name Relationship Age SSN/TIN

_____
Address

e. Premium $ _____ ☐ Lump Sum _____ ☐ 1035 exchange ☐ Planned Periodic Premium _____

BACKGROUND/HEALTH QUESTIONS **YES** **NO**

11. Does any proposed insured have any of the coverages listed below inforce or have any pending application for such coverage with this Company or any other company? Check all applicable boxes. ☐ ☐
If "Yes,"

Name Co. Name Amt. of Coverage/Benefit Pol. No.
☐ Life ☐ Health ☐ Long-term Care ☐ Disability/Period _____ ☐ Annuity

Name Co. Name Amt. of Coverage/Benefit Pol. No.
☐ Life ☐ Health ☐ Long-term Care ☐ Disability/Period _____ ☐ Annuity

Name Co. Name Amt. of Coverage/Benefit Pol. No.
☐ Life ☐ Health ☐ Long-term Care ☐ Disability/Period _____ ☐ Annuity

12. Will any existing insurance coverage or annuity contract be replaced or changed if any policy applied for is issued? ☐ ☐
If "Yes," complete the necessary replacement forms and provide details below.

Name Co. Name Type of Coverage Amt. of Coverage/Benefit Pol. No.

Name Co. Name Type of Coverage Amt. of Coverage/Benefit Pol. No.

Name Co. Name Type of Coverage Amt. of Coverage/Benefit Pol. No.

13. Within the past 5 years, has any proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? If "Yes," provide details below ☐ ☐

Name Type Date of Last Use Frequency/Amount

Name Type Date of Last Use Frequency/Amount

14. Has any proposed insured ever had an application for insurance modified, rated, declined, postponed, or withdrawn? ☐ ☐
If "Yes," provide details below.

Name Type of Coverage Date Details

Name Type of Coverage Date Details

15. Within the past 5 years, has any proposed insured been convicted of, paid a fine/ticket or pled guilty to reckless driving, driving while intoxicated, or had a driver's license revoked or suspended, or, within the past 3 years, had any moving traffic violations? ☐ ☐
If "Yes,"

Name Type of Violation Duration (if applicable) Date of Incident State of Incident

Details

Name Type of Violation Duration (if applicable) Date of Incident State of Incident

Details

16. Has any proposed insured ever been convicted of, pled guilty to, or pled no contest to a felony, or is any such charge pending against him/her? ☐ ☐
If "Yes,"

Name Date of Occurrence County and State Disposition

Details

Name Date of Occurrence County and State Disposition

Details

	YES	NO
17. Does any proposed insured intend to travel or reside outside of the United States within the next year?	☐	☐

If "Yes,"

Name(s) _____ City/Country where traveling _____ Length of Stay _____ Times Per Year _____

Purpose of Travel _____ Do you plan to visit non-urban areas _____ Trips outside of U.S. in prior two years _____

Name(s) _____ City/Country where traveling _____ Length of Stay _____ Times Per Year _____

Purpose of Travel _____ Do you plan to visit non-urban areas _____ Trips outside of U.S. in prior two years _____

18. Is any proposed insured **NOT** a citizen of the United States? ☐ ☐

If "Yes,"

Name of proposed insured _____
Date of entry into the U.S. _____
Name of country of citizenship _____
Have Permanent Resident Card? ☐ Yes ☐ No
If "Yes," Provide A # _____
If No, does the proposed insured have a Visa? ☐ Yes ☐ No
If "Yes," Type of Visa: _____ (provide copy)
Intentions after expiration of Visa _____
Does the proposed insured own a home in the U.S.? ☐ Yes ☐ No
Are any family members U.S. Citizens or Permanent Residents? ☐ Yes ☐ No
If "Yes," give details _____
If no Permanent Resident Card and no Visa, please explain: _____

Name of proposed insured _____
Date of entry into the U.S. _____
Name of country of citizenship _____
Have Permanent Resident Card? ☐ Yes ☐ No
If "Yes," Provide A # _____
If No, does the proposed insured have a Visa? ☐ Yes ☐ No
If "Yes," Type of Visa: _____ (provide copy)
Intentions after expiration of Visa _____
Does the proposed insured own a home in the U.S.? ☐ Yes ☐ No
Are any family members U.S. Citizens or Permanent Residents? ☐ Yes ☐ No
If "Yes," give details _____
If no Permanent Resident Card and no Visa, please explain: _____

19. Within the past 5 years, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the next 2 years? ☐ ☐

If "Yes," Name _____ Details _____
Name _____ Details _____
If "Yes," submit an Aviation Questionnaire.

20. Within the past 5 years, has any proposed insured engaged in motor sports events or racing (auto, truck, cycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning)? ☐ ☐

If "Yes," Name _____ Details _____
Name _____ Details _____
If "Yes," submit an Avocation Questionnaire.

AGENT USE ONLY

MEDICAL EXAMINATION WILL BE SCHEDULED FOR: Primary Proposed Insured ☐ ☐
Additional Proposed Insured ☐ ☐

For any person who will be scheduled for a medical examination, please complete Questions 21. a. and 21. b.

21. a. Within the past 5 years, has any proposed insured been diagnosed as having or been treated for alcoholism, cancer or malignancy, HIV, heart attack, angina, kidney failure, Type 1 diabetes, emphysema, organ transplant or stroke, or been advised to have any diagnostic test or surgery not yet performed? ☐ ☐

If "Yes," name(s) of proposed insured(s) _____

b. Is any proposed insured age 71 or older? ☐ ☐

If "Yes," name(s) of proposed insured(s) _____

If "Yes" to 21. a. or 21. b., **no premium may be collected with this application.**

YES **NO**

Questions 22 through 37 are only for persons proposed for insurance who are NOT expected to be subject to a Medical Examination. All applicants may, nevertheless, be subject to a Medical Examination at the Company's option.

Please complete questions 22-37 for each person who did not check "Yes" above, and for each child who is not an additional proposed insured:

22. a. Primary Proposed Insured: Height _____ Weight _____ b. Additional Proposed Insured: Height_____ Weight _____
    c. Has any proposed insured had a change in weight of 10 or more pounds in the past year? ☐ ☐
    If "Yes," Name _____ Details _____
    If "Yes," Name _____ Details _____

23. Is any proposed insured currently taking any medication or under medical observation, treatment, or therapy? ☐ ☐
    If "Yes," Name _____
    Give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.
    _____
    _____
    If "Yes," Name _____
    Give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.
    _____
    _____

24. Within the past 5 years, has any proposed insured consulted a doctor or been a patient in a hospital, clinic or treatment facility, or gone to a hospital emergency room or walk-in or similar clinic for medical care or consultation? ☐ ☐
    If "Yes," Name _____
    Date(s) _____ Duration _____ Type of Visit/Stay_____
    (hospital, clinic, treatment facility, ER, walk-in or clinic)
    Name, Address, and Telephone Number of the doctor, hospital, clinic, ER or treatment facility _____
    _____
    Give details_____
    Name _____
    Date(s) _____ Duration _____ Type of Visit/Stay_____
    (hospital, clinic, treatment facility, ER, walk-in or clinic)
    Name, Address, and Telephone Number of the doctor, hospital, clinic, ER or treatment facility _____
    _____
    Give details_____

25. In the immediate family of any proposed insured, has anyone been diagnosed or treated by a member of the medical profession for high blood pressure, heart disease prior to age 60, kidney disease, stroke, diabetes prior to age 55, sickle cell anemia, cerebrovascular disorder, aneurysm, or cancer? ☐ ☐
    If "Yes," Name of Proposed Insured: _____
    Relationship to Proposed Insured_____ Type/Details _____
    Name of Proposed Insured: _____
    Relationship to Proposed Insured_____ Type/Details _____

	YES	NO
26. Has any proposed insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for high blood pressure?	☐	☐

If "Yes," Name _____
Date of diagnosis _____
Treatment _____
Last blood pressure reading and date _____
Highest blood pressure reading in past 12 months _____
Average blood pressure reading _____
Name and address of physician treating high blood pressure.

If "Yes," Name _____
Date of diagnosis _____
Treatment _____
Last blood pressure reading and date _____
Highest blood pressure reading in past 12 months _____
Average blood pressure reading _____
Name and address of physician treating high blood pressure.

	YES	NO
27. Has any proposed insured ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes?	☐	☐

If "Yes," Name _____
Date of diagnosis _____
Describe treatment _____
List any disability related to diabetes _____
Last blood sugar or HA1C reading and date _____
Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes? ☐ Yes ☐ No
If "Yes," provide details _____
Name and address of physician treating diabetes

If "Yes," Name _____
Date of diagnosis _____
Describe treatment _____
List any disability related to diabetes _____
Last blood sugar or HA1C reading and date _____
Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes? ☐ Yes ☐ No
If "Yes," provide details _____
Name and address of physician treating diabetes

	YES	NO
28. Within the past 5 years, has any proposed insured consumed alcoholic beverages?	☐	☐

If "Yes," Name _____ Average No. of drinks per week _____
Maximum No. of drinks per day _____ Type (Beer, Wine, Liquor) and Date of last use _____
Name _____ Average No. of drinks per week _____
Maximum No. of drinks per day _____ Type (Beer, Wine, Liquor) and Date of last use _____

	YES	NO
29. Has any proposed insured ever received medical treatment or counseling from a physician for, or been advised by a physician to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has any proposed insured used such a non-prescribed drug or controlled substance, or any prescription medication other than as prescribed by a physician?	☐	☐

If "Yes," Name _____ Date(s) _____ Duration _____ Type _____
Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) _____

Name _____ Date(s) _____ Duration _____ Type _____
Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) _____

	YES	NO
30. Within the past 10 years, has any proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐

If "Yes," Name _____ Details _____

Name and Address of Physician _____

If "Yes," Name _____ Details _____

Name and Address of Physician _____

31. Within the past 12 months, has any proposed insured had one or more sores that have not healed, had changes in the appearance of a mole, experienced bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, numbness, or paralysis for which the cause is not known and for which a doctor has not been consulted?	☐	☐

If "Yes," Name _____ Date(s)_____ Duration_____ Type_____

Details_____

Name _____ Date(s)_____ Duration_____ Type_____

Details_____

32. In the past 24 months, has any proposed insured been advised by a member of the medical profession concerning any abnormal diagnostic test results, or been advised to have any diagnostic tests (including self-administered), treatment or surgery which was not completed or does any proposed insured have test results pending except those tests related to the Human Immunodeficiency Virus (AIDS virus)?	☐	☐

If "Yes," Name _____ Date(s)_____ Type_____

Details_____

(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)

Name _____ Date(s)_____ Type_____

Details_____

(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)

33. Does any proposed insured have a pending appointment with any physician or other medical professional or have the intent to make such appointment within the next 60 days?	☐	☐

If "Yes," Name _____ Date(s)_____ Type_____

Details_____

(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)

Name _____ Date(s)_____ Type_____

Details_____

(including name, address and telephone number of the doctor, hospital, clinic or treatment facility)

34. Is any proposed insured currently a patient in or been advised to enter a hospital, nursing home, hospice or assisted living facility?	☐	☐

If "Yes," Name _____ Details _____

Name _____ Details _____

35. Has any proposed insured made claim for or received disability (other than for routine pregnancy) or Worker's Compensation benefits in the past 5 years?	☐	☐

If "Yes," Name _____ Type of Disability_____ Details_____

Name _____ Type of Disability_____ Details_____

36. Within the past 24 months, has any proposed insured:		
(a) been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing or shortness of breath?	☐	☐
(b) received home health care services, physical therapy or rehabilitation therapy?	☐	☐
(c) resided in senior citizen's housing or a retirement or assisted living community?	☐	☐
(d) required assistance or supervision with or had any limitations in performing, any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)?	☐	☐
(e) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside the home or preparing meals?	☐	☐

	YES	NO
37. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for any of the following. (If "Yes," check applicable boxes below.)		
(a) heart disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, high cholesterol or other disorder of the heart?	☐	☐
(b) a blood clot, aneurysm, stroke, transient ischemic attack, or other disease or disorder of the arteries or veins?	☐	☐
(c) cancer, malignant tumor or growth, leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma, masses, cysts, polyps or other similar abnormalities?	☐	☐
(d) a disease or disorder of the thyroid or other glands or a disease or disorder of the immune or lymphatic system?	☐	☐
(e) a disease or disorder of the digestive system, throat, esophagus, stomach, intestine, liver, pancreas, or gall bladder?	☐	☐
(f) a disease or disorder of the urinary tract, kidneys, bladder, or prostate, or polycystic kidneys, or protein in the urine?	☐	☐
(g) a disease or disorder of the respiratory system, or asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, or other lung disorder?	☐	☐
(h) a disease or disorder of the nervous system, brain, or spinal cord, or cerebral palsy, multiple sclerosis, paralysis or seizures?	☐	☐
(i) anxiety, depression or other mental disorder?	☐	☐
(j) Alzheimer's disease or dementia?	☐	☐
(k) glaucoma, macular degeneration, optic neuritis?	☐	☐
(l) a disease or disorder of the blood, or anemia, hemophilia, sickle cell anemia?	☐	☐
(m) a disease or disorder of the muscles or bones, including but not limited to the back or joints?	☐	☐
(n) a disease or disorder of the reproductive system?	☐	☐

Explain "Yes" answers to Questions 36-37.

Name	Date	Duration	Details	Name(s) and Address(es) of Doctor(s) or Hospital(s)

The space below may also be used to elaborate on any other question on this application.

OWNER'S CERTIFICATION

Under penalties of perjury, I certify that the following number, _____ , is my correct taxpayer identification number, AND

Under penalties of perjury, I certify that I am not subject to backup withholding because:
(a) I am exempt from backup withholding, or
(b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or
(c) the IRS has notified me that I am no longer subject to backup withholding, AND

Under penalties of perjury, I certify that I am a U.S. person (including a U.S. resident alien).

You must cross out item (b) 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 in your tax return.

X _____ _____
Signature of Owner — Date

Consent to Insurance on Life of Minor Primary Proposed Insured

I hereby consent to the insurance plan, amount and beneficiary designation shown on the application and also reaffirm the answers to the health questions as they pertain to the Minor Primary Proposed Insured.

X _____ _____
Signature of Biological/Adoptive Father or Mother or of Legal Guardian — Date

X _____ _____
Signature of Biological/Adoptive Father or Mother or of Legal Guardian — Date

---

Consent to Children's Term Rider on Life of Minor Stepchild of Primary Proposed Insured or Additional Proposed Insured

I hereby consent to the insurance plan and amount shown on this application as to any biological and adopted child(ren) of mine listed in this application. I understand that the beneficiary of such applied-for coverage on such child(ren) will be the Owner of the policy. I affirm the answers to the health questions on this application as to such child(ren).

X _____ _____
Signature of Biological/Adoptive Father or Mother — Date

AGENT'S CERTIFICATION

I certify that I have asked each question and that the answers have been truly and accurately recorded as given. I have recorded any unfavorable information which I have knowledge of concerning any proposed insured. I confirm that any and all signatures of the Primary Proposed Insured, Additional Proposed Insured, Owner and Witness(es) in this application were signed in my presence.

_____ _____
Date — Signature of Licensed Agent

ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZATION – NOTICE

I, the Primary Proposed Insured (and any Owner or Additional Proposed Insured signing below), by my signature set forth hereafter:

Acknowledge that, if a Conditional Receipt was issued to me as a result of this application, I have read, or have been given the opportunity to read or to have read to me, all terms and provisions of such Conditional Receipt.

Agree that, under the Conditional Receipt, if any, given to me as the result of this application and under any additional pending application for other life, accident and/or health insurance coverage from American General Life Insurance Company ("the Company"), the aggregate liability on account of all coverages applied for with the Company will be the amount of coverage applied for or $250,000, whichever is less.

Agree that any temporary insurance arising under the terms of any Conditional Receipt given to me as a result of this application shall become effective only if and when such Conditional Receipt is delivered to the Owner.

Agree that all statements and answers in this application are complete and true to the best of my knowledge and belief and are the basis for any policy issued by the Company and agree that no information shall be deemed to have been given to the Company unless it is set forth in this application or in any supplemental application.

Agree that, except as stated in any Conditional Receipt, if such Conditional Receipt was given to me as a result of this application, the insurance will take effect on the Policy Date shown in the Policy if (a) the Policy has been delivered to me; (b) the first full modal premium for the Issued Policy has been paid while each proposed insured is alive; and (c) there has been no change in the health of any proposed insured that would change the answer to any question in this or any supplemental application before the conditions in items (a) and (b) above are met.

Agree that no agent of the Company or Medical Examiner has authority to waive any answer or otherwise modify this or any supplemental application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

Authorize: (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for insurance policy, and (3) the duration of a claim for benefits.

ACKNOWLEDGE receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; and (c) Investigative Consumer Report.

NOTICE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE: If a proposed insured's answers on this application are incorrect or untrue, the Company may have the right to deny benefits and/or rescind coverage.

PRIMARY PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.

ADDITIONAL PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.

AGENT - To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? ☐ Yes (Explain) ☐ No

Signed at _____ _____ , _____ X _____
City State Date SIGNATURE OF PRIMARY PROPOSED INSURED

X _____ X _____
SIGNATURE OF ADDITIONAL PROPOSED INSURED (IF APPLICABLE)
SIGNATURE OF OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

X _____ X _____
SIGNATURE OF WITNESS (IF APPLICABLE)
SIGNATURE OF LICENSED AGENT

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AGENT'S REPORT

1. Primary Proposed Insured:
   If amount of insurance being applied for is $100,000 or more, identify rate class quoted:
   ☐ Preferred Plus ☐ Preferred NT
   ☐ Standard Plus ☐ Standard
   ☐ Preferred Tobacco ☐ Standard Tobacco
   Home Telephone No. _____
   Best time to call _____ ☐ AM ☐ PM
   Business Telephone No. _____
   Best time to call _____ ☐ AM ☐ PM
   Email Address _____

2. Additional Proposed Insured:
   If amount of insurance being applied for is $100,000 or more, identify rate class quoted:
   ☐ Preferred Plus ☐ Preferred NT
   ☐ Standard Plus ☐ Standard
   ☐ Preferred Tobacco ☐ Standard Tobacco
   Home Telephone No. _____
   Best time to call _____ ☐ AM ☐ PM
   Business Telephone No. _____
   Best time to call _____ ☐ AM ☐ PM
   Email Address _____

3. Owner's Telephone No. _____
   Email Address _____

4. Payor's Telephone No. _____
   Email Address _____

5. Beneficiary Name(s) _____
   Email Address(es) _____

6. Household Annual Earned Income _____

7. If the adult proposed insured is non-wage earning (i.e. homemaker), provide amount of life insurance coverage on working spouse.
   _____

8. What is your relationship to the proposed insured(s)?
   _____

9. Is more than one application being submitted at this time or pending for the proposed insured, family members or business associates?
   ☐ Yes ☐ No
   If "Yes," provide details in Remarks section on next page.

10. Did you personally see all proposed insured(s) when the application was written? ☐ Yes ☐ No
    If "No," provide details in Remarks section on next page.

11. Do you have knowledge of any unfavorable information regarding the proposed insured(s) which has not been fully disclosed in the application? ☐ Yes ☐ No
    If "Yes," provide details in Remarks section on next page.

12. Is there to be any split commission with another agent?
    ☐ Yes ☐ No
    If "Yes," provide details in Remarks section on next page.

13. For Any Associated Plan or Stand-alone Policy:
    a. Name of Proposed Insured and 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 and 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 and 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

14. a. Did you give the Owner a Conditional Receipt? ☐ Yes ☐ No
    b. If "Yes," did you bring the conditions and limitations of any conditional receipt to the attention of the Owner? ☐ Yes ☐ No

15. Is Primary Proposed Insured or Additional Proposed Insured under age 16? ☐ Yes ☐ No
    If "Yes," provide amount of life insurance in force on the head of household in residence of the child.
    Relationship _____ Amount $ _____
    If "Yes," provide amount of life insurance on each of the other members (include siblings) of the household (specify relationship of each family member). _____
    _____
    If juvenile insurance exceeds Company guidelines, provide explanation. _____
    If Accidental Death is applied for, what is the total amount of accident coverage applied for and in force on the juvenile proposed insured.
    $ _____
    If greater than $25,000, explain need for accident coverage. _____
    _____

16. Agent's Daytime Phone Number _____
    Agent's Email Address _____

17. **NON-PREMIUM FINANCING CERTIFICATION**

Will the insurance contemplated by this application be premium financed, other than by a split-dollar agreement? ☐ Yes ☐ No
If "Yes," provide explanation in the REMARKS section below.

If "No," I certify, to the best of my information and belief, that none of the premiums for the policy(ies) sought with the application(s) for life insurance referenced herein will be financed by a split-dollar agreement.

Agent's Signature _____

Agent's Name (Print) _____ Date _____

Local Office Name/Number	State	Service No	Agency	Split Comm %	Family No

AMOUNT OF COLLECTION

Name of Proposed Insured _____ Plan _____ Premium Collected $_____
Name of Proposed Insured _____ Plan _____ Premium Collected $_____
Name of Proposed Insured _____ Plan _____ Premium Collected $_____

Authorized Signature _____ Date _____

REMARKS

AIG

American General Life Insurance Company
P O Box 305355 • Nashville, Tennessee 37230-5355 • 800-888-2452

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

AUTOMATIC BANK CHECK (ABC) AUTHORIZATION

POLICY NUMBER	NAME OF INSURED	POLICY NUMBER	NAME OF INSURED

ABC TYPE ☐ **Retail** ☐ **Employer Sponsored ABC**

PAYMENT OPTIONS: Used for new business policies. Please select ONLY one payment option:

☐ **Draft Initial Premium and Draft Subsequent Premiums which may be different from the Initial Premium**

NEW ISSUES - If Draft Initial Premium is selected, American General Life Insurance Company ("Company") will promptly process an electronic funds transfer (EFT) for the premium amount shown on the application upon receipt of this Authorization at its office at American General Center, Nashville, Tennessee 37250-0001 and Draft Subsequent Premiums which may be different from the Initial Premium. An EFT for the initial premium will be processed (subject to refund) regardless of whether a policy is issued.

CONVERSIONS, TRANSFERS, EMPLOYER SPONSORED ABC (Worksite) and Greater than $500,000 Face Amount - If Draft Initial Premium is selected, no insurance becomes effective until the Company receives the Initial Premium. The Initial Premium will be drafted upon the issue of the policy.

☐ **Collect Initial Premium and Draft Subsequent Premiums which may be different from the Initial Premium**

Amount Collected: $_____

☐ **Collect On Delivery of Policy (COD) and Draft Subsequent Premiums which may be different from the Initial Premium**
To be used for Trial Apps only

Withdrawal Day _____ **(1st thru 28th only)** ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

Bank Account Information: ☐ **Checking Account** ☐ **Savings Account** *Note: The default will be Checking if a selection is not made
Voided Check Highly Recommended.

Bank Account Routing/Transit #: _ _ _ _ _ _ _ _ _ Bank Name: _____

Bank Account Number: * _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ * **Do not use credit/debit card.**

Bank Account Owner Name(s): _____
(Please Print)

Bank Account Owner SS# ___-___-_____ Bank Account Owner Date of Birth (mm/dd/yyyy) ____/____/_____

Bank Account Owner Full Address:

Street: _____ Phone: _____ Email: _____

City: _____ State: _____ Zip: _____

AGREEMENT: I (we) authorize American General Life Insurance Company, subject to my elections above, to initiate with the Financial Institution indicated by me (us) debit entries to the provided checking/savings account for any full or partial balance due for initial and/or subsequent premiums, as provided by this form. This authority is to remain in effect until the Company or Financial Institution has received **written notification of termination of the ABC account, from me (or either of us), at least 30 days prior to the collection date,** or until the ABC account otherwise terminates. It is agreed that:

1. No liability shall be incurred by the Company or other issuing company of the policy by reason of the dishonor of such debit entries.
2. Any notice of premiums due shall be waived and the bank account draft shall serve as a receipt. No credit is applied until the Company receives actual payment in its office at American General Center, Nashville, Tennessee 37250-0001. The ABC account authorization shall in no way alter or amend the provisions of the policy(ies). Request by me (us) to change the draft date does not alter the due date, and the Company will not waive or modify such due date for the grace period.
3. I (we) understand that no insurance applied for (except coverage pursuant to the terms of a separately-provided conditional receipt, if any) will become effective unless the Company issues a policy, the first premium is paid, and any other terms and conditions of the policy are met.
4. In the event I (we) later elect to cancel this authorization or if the Company determines I (we) am no longer eligible for ABC, I (we) acknowledge that the premium shall be payable in the amount and manner as provided in the policy.
5. This ABC account authorization shall continue in effect and premiums will continue to be debited, in accordance with this agreement unless or until terminated by the Company or by me (us), **by written notice to the other party at least 30 days prior to the collection date**. In addition, the Company may terminate the ABC account immediately if any charges are not paid upon presentation.
6. I understand and agree that a debit may be drawn from the above account for any premium(s) due on the above policy(ies) and American General Life Insurance Company will not be responsible for any change charges/fees related to this transaction.
7. 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.

Bank Account Owner Signature: _____ Date: _____

If Joint Account:
Bank Account Owner Signature: _____ Date: _____

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(NOT TO BE COMPLETED FOR PAYROLL DEDUCTION MODES) CONDITIONAL RECEIPT FOR PREMIUM DEPOSIT

This Receipt is Valuable. Keep It in a Safe Place.

On this date, American General Life Insurance Company ("the Company") has received $_____ for life insurance applied for on _____. We agree to provide temporary insurance if (a) this deposit is equal to at least
(Primary or Additional Proposed Insured)

one twelfth (1/12) of the annual premium for the policy applied for and (b) all persons for whom application is made are insurable in the opinion of the Company's authorized underwriters for the plan, insurance amount, and premium applied for on the date of this premium deposit and on the date of any required medical examination.

ANY TEMPORARY INSURANCE UNDER THIS CONDITIONAL RECEIPT IS SUBJECT TO THE AMOUNT AND TERMS OF THE POLICY APPLIED FOR EXCEPT THAT THE AGGREGATE LIABILITY FOR TEMPORARY INSURANCE FOR EACH PROPOSED INSURED UNDER THIS CONDITIONAL RECEIPT AND UNDER CONDITIONAL RECEIPT FOR ANY ADDITIONAL, PENDING APPLICATION FOR OTHER LIFE, ACCIDENT AND/OR HEALTH INSURANCE COVERAGE FROM THE COMPANY WILL BE THE AMOUNT OF COVERAGE APPLIED FOR OR $250,000.00, WHICHEVER IS LESS. IF TEMPORARY INSURANCE EXISTS UNDER THIS CONDITIONAL RECEIPT, IT WILL END UPON DELIVERY OF A POLICY OR 60 DAYS AFTER THE DATE OF THIS RECEIPT, IF EARLIER.

No agent has authority to change or waive the terms and conditions of this Receipt. This receipt is not valid if its date differs from that in the application or if any check tendered as a premium deposit shown above is not honored when presented for payment.

_____ , _____	_____	_____	_____
Date	Local Office	Agency No.	Signature of Licensed Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

ICC11 AGLA1000 (0611) CR

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the 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 in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the 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.

American General Life Insurance Company, or its reinsurer(s), 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.

ICC11 AGLA1000 (0611) MIB

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.

NOTICE TO HOLDER OF CONDITIONAL RECEIPT

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:
(a) decline to issue insurance; or
(b) issue a policy other than as applied for and you do not accept it.

If you do not receive a policy within 60 days from the date of deposit, return this Receipt for refund to our Local Office or to our office at American General Center, Nashville, TN 37250-0001.

ICC11 AGLA1000 (0611) CR

NOTICE OF INFORMATION PRACTICES

American General Life Insurance Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes)

ICC11 AGLA1000 (0611) NIP

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.

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_____ , _____	_____	_____	_____
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ICC11 AGLA1000 (0611) CR

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ICC11 AGLA1000 (0611) NIP

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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.

SUMMARY AND DISCLOSURE NOTICE FOR ACCELERATED BENEFITS

Receipt of a benefit under the Accelerated Death 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 DEATH 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 Death 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 Death 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.

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.

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 an Accelerated Death 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.

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 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 illustration demonstrating the effect of payment of an accelerated benefit on the values of the policy to which the rider is attached. The example shown assumes that $25,000 is being accelerated.

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 Death 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.

To assist you in making a decision about electing a Flexible Accelerated Benefit under the rider, a statement showing the amount of benefit payable 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 benefits are payable under the rider.

Notice Regarding Substitution of AGLA Select*Choice* Accelerated Benefit Rider for Existing No-Cost Accelerated Benefit Riders

If I am applying to substitute an AGLA Select*Choice* 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 AGLA Select*Choice* 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 AGLA Select*Choice* 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 AGLA Select*Choice* 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 and received a copy of this Summary and Disclosure or will be provided a copy with my policy.

_____ _____

Signature of Owner Date

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

_____ _____

Signature of Agent Date

Amercian General Life Insurance Company
American General Center • Nashville, Tennessee 37250-0001

American General Life Insurance Company
American General Center
Nashville, TN 37250-0001

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

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.

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 adversely 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:

_____

_____

_____

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.

_____
Name of Proposed Insured (Print)

_____
Signature of Proposed Insured or Parent/Guardian

_____
Date

American General Life Insurance Company
American General Center
Nashville, TN 37250-0001

HIPAA Authorization - Life New Business

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

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

I, the Proposed Insured above or the Proposed Insured's Personal Representative acting on behalf of the Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company and its affiliates (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.

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

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

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

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

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

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Insurance Company, Attn: Underwriting Department, American General Center, Nashville, TN 37250. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

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

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

X _____ _____
Signature of Proposed Insured or Proposed Insured's Personal Representative — Date

X _____ _____
Printed Name of Proposed Insured or Proposed Insured's Personal Representative — Relationship

X _____ _____
Witness Signature (if required) — Date

_____ _____
Description of Authority of Personal Representative — Control Number/Policy Number

American General Life Insurance Company
American General Center • Nashville, TN 37250-0001

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize that the persons named herein give certain data to: (1) American General Life Insurance Company (hereinafter referred to as "Company"); and (2) its reinsurers; and (3) its legal representative. The data that can be released by such persons must pertain to information about me, or about my spouse or civil union partner and/or any minor child if proposed for insurance, with regard to: (1) the diagnosis, treatment and prognosis of any physical or mental condition; or (2) any drug and/or alcohol use history; or (3) any other health data or information. Any of these persons may release such data: a doctor who is licensed; or a medical practitioner; or a hospital; or a clinic or other medical or medically related facility; or an insurance company; or the Medical Information Bureau; or a consumer reporting agency; or an employer.

I understand that any data obtained: (1) will be used by the Company to determine eligibility for insurance; and (2) will not be released by the Company to any person or organization, except: (a) the Company's reinsurers; and (b) the Medical Information Bureau; and (c) other companies to whom I have applied or may apply for insurance coverage; and (d) other persons or organizations who perform business or legal services in connection with my application; and (e) as may be required by law.

I authorize the Company to obtain an investigative consumer report on me. I know that I or my authorized representative may request to receive a copy of this Authorization. I also acknowledge receipt of the "Notice of Insurance Information Practices".

A photographic copy of this Authorization shall be as valid as the original. Such copy shall be valid for: (a) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance; and (b) the term of coverage of an accident and sickness policy or for the duration of a claim for other benefits for the purpose of collecting information in connection with a claim.

❑ I elect to be interviewed if an investigative consumer report is prepared in connection with this application.

Date _____, 20____ _____ _____

Signature of Proposed Insured

Signature of Insured Spouse or Civil Union Partner

_____	_____	_____	_____	_____
Name of Minor Child	Name of Minor Child	Name of Minor Child	Name of Minor Child	Name of Minor Child

American General Life Insurance Company
American General Center • Nashville, TN 37250-0001

NOTICE OF INSURANCE INFORMATION PRACTICES

This description of the information practices of American General Life Insurance Company and its agents is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state.

Collection of Information

The collection of certain types of information is essential for the proper handling of your insurance. In general, this information covers age, occupation, physical condition, health history, mode of living and avocations. We obtain information from you, medical professionals and institutions, employers and business associates, friends and neighbors, public records, other insurance companies and insurance support organizations. We collect information by exchanges of correspondence, by phone, or by personal contact. In some cases we may ask an insurance support organization to collect and report information to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosure by American General Life Insurance Company

We may disclose information, in accordance with law, without specific authorization to:

a. other persons or organizations performing business, professional, or insurance services for us or our agents.
b. your physician if your medical examination revealed something not known to you.
c. auditors when examining our company's operations.
d. our reinsurers, if your policy was reinsured.
e. medical care institutions or medical professionals to verify that you have health coverage with us.
f. another insurance company to which you apply for benefits.
g. your American General Life agent to assist in providing service to you.
h. insurance support organizations to prevent fraud in insurance transactions.
i. law enforcement agencies to assist in the prevention or prosecution of fraud or to alert such agencies to the possibility of illegal conduct.
j. persons or organizations doing research or actuarial studies. No person is ever individually identified in reports of such studies.
k. an affiliated company which may contact you about availability of an insurance product or service.
l. an unaffiliated person or organization for marketing purposes, but only if you do not object.
m. group policyholders auditing our records of their group programs or receiving reports of claims experience.
n. insurance regulatory authorities.

Please understand that the above lists disclosures which **may** be made, not disclosures which are always made. Also, we provide **only** as much information as is reasonably necessary, and only persons with legitimate reasons have access to our files.

Your Rights of Access to Information About You

You have certain rights of access to information about you in our files. To maintain the security of that information, access will be permitted only after proper identification.

Should you wish access to that information, you must send a signed, written request to American General Life Insurance Company, American General Center, Nashville, TN 37250-0001, and furnish your full name, your address, telephone number and policy number. Your request must reasonably describe the recorded personal information to which you wish access. Within thirty business days after receiving your request, we will contact you to give you the information. If you wish, we will mail copies of the records to you, or you may visit our office, where you will be permitted to see and copy the records. We may charge a reasonable fee to cover the costs of making those copies.

Also, we will identify the persons or organizations to whom we have disclosed items of information within the last two years or the persons or organizations to whom such information would normally have been disclosed.

Your right to access has limitations. We will identify the person or institution which was the source of information but not individuals providing information in a personal capacity. Also, we are not required to provide access to information obtained in connection with, or in anticipation of a claim for policy benefits or a civil or criminal proceeding.

In some cases, we may choose to disclose medically related information through a medical professional selected by you, who is licensed to provide medical care relevant to the nature of the information.

Correction or Deletion of Information

If, after review, you believe that information in our files is incorrect, you may request, in writing, that we correct, amend or delete that which is incorrect. We will contact you within thirty business days after receipt of your request.

If we agree that certain items should be corrected, amended or deleted, we will send notification of the change to any person to whom we may have disclosed the original information during the preceding two years, and we will also notify any insurance support organization to whom we have disclosed the information or any such organization that may have furnished the original information.

If we do not agree to make the correction, amendment or deletion, you may file with us a brief statement stating what you believe to be the correct, relevant or fair information and why you disagree with our decision. Your statement will become a permanent part of our file and will be made part of any future disclosure of the original information. In addition, copies of your statement will be sent to any person or insurance support organization to whom the original information was disclosed.

American General Life Insurance Company and its agents hope that you will find this explanation of our information practices to be helpful, for we take our responsibilities and your rights very seriously. If you should have any further questions about the items just discussed, please send your request to Director, New Business Department, American General Life Insurance Company, American General Center, Nashville, Tennessee 37250-0001.

American General
Life Companies

Notice Regarding Replacement
New Jersey Version

☒ **American General Life Insurance Company**

Please check the appropriate Company box

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.

X _____ _____
Applicant's Signature and Printed Name **Date**

X _____ _____
Producer's Signature and Printed Name **Date**

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.

X _____ _____

Applicant's Signature and Printed Name **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 and Printed Name **Date**

American General Life Insurance Company
American General Center
Nashville, TN 37250-0001

Request For Policy Illustration

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.

_____ _____
(Signature of Proposed Owner) (Date)

AGENT'S STATEMENT:

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

_____ _____
(Signature of Agent) (Date)

_____
Local Office

_____
Agency

AGLA8122 REV0114

American General Life Insurance Company
American General Center
Nashville, TN 37250-0001

Request for Policy Quotation

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.

_____ _____
(Signature of Proposed Owner) (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.

_____ _____
(Signature of Agent) (Date)

_____
Local Office

_____
Agency

AGLA8124 REV0114

American General Life Insurance Company
American General Center
Nashville, TN 37250-0001

Request to Transfer Funds

1. CUSTOMER INFORMATION

Owner's Name & Address (if joint ownership, both must be listed)

_____

_____

_____

_____

Social Security/Tax ID No.:_____

Joint Owner SSN/Tax ID No.:_____

Name & Address of Current Company (No P.O. Boxes)

_____

_____

_____

_____

Telephone Number: _____

Fax Number:_____

Policy/Contract/Account No.: _____

2. POLICY OR CONTRACT INFORMATION AND INSTRUCTIONS TO AMERICAN GENERAL LIFE INSURANCE COMPANY (AMERICAN GENERAL LIFE)

If an annuity/contract or life insurance policy is referenced above, that document is:

☐ **Enclosed**

☐ **Lost/Destroyed** (I certify that the policy or contract is lost or destroyed. In addition, I certify that the policy or contract has not been assigned or pledged as collateral.)

My Exchange, Transfer, Rollover or Conversion funds are to be applied to:

☐ A new contract (application attached)

☐ **American General Life existing contract, number** _____ **If the above referenced Policy/Contract/Account No. is an annuity or life insurance policy, check here** ☐ **indicating this is a replacement transaction. (This option is not available for 1035 Exchanges.)**

3. TRANSFER FUNDS – Please select only one type of transfer based on source of funds per form.

a. Trustee-to–Trustee Transfer (Qualified plan transfers, direct rollovers)

Transfer From (check one):

☐ Traditional IRA (TRAD IRA)
☐ Employer's qualified retirement plan (including 401(k)
☐ Governmental Deferred Comp. Plan (Section 457)
☐ Tax Sheltered Annuity Plan (403b)
☐ Keogh Plan (HR10)
☐ Qualified Bond Purchase Plan
☐ SEP IRA

** IF CONVERTING AN ABOVE PLAN TO A ROTH IRA, SEE 3B BELOW; **DO NOT** COMPLETE 3A.

☐ ROTH IRA – Require current policy issue date _____ Transfer to ROTH IRA

Transfer To: (check one):

☐ TRAD IRA
☐ SEP IRA
☐ Inherited IRA

Has the client contacted the current company to request the rollover? ☐ **Yes** ☐ **No**

If yes, does the current company require this form be forwarded to it? ☐ **Yes** ☐ **No**

For trustee-to-trustee transfers, please provide all the forms required by the existing trustee or custodian, and a copy of the most recent account statement.

b. Conversion to ROTH IRA

Conversion From (check one): ☐ TRAD IRA ☐ SEP IRA ☐ SIMPLE IRA ☐ EMPLOYER QUALIFIED RETIREMENT PLAN

The funds converted may be taxable to the IRA Owner. Complete Tax Withholding Election and Representation section on page 2.

c. Section 1035 Exchange (Absolutely assigning and exchanging an existing life insurance policy or nonqualified annuity policy)

☐ **Check here to request a Section 1035 Exchange** (Please Print Insured/Owner Name below)

Insured/Annuitant: _____ **Owner:**_____

Joint Owner: _____

Existing Contract Type: ☐ Life Insurance (To Life or Annuity) ☐ Endowment (To: Life or Annuity)
☐ Annuity (To: Annuity Only)

The undersigned hereby assign(s) and transfer(s) all rights, title, and interest in the policy or contract indicated in Section 1 of this form to American General Life. This assignment is to be part of a tax-free exchange under Internal Revenue Code Section 1035(a). The undersigned is(are) aware that American General Life intends to surrender the policy or contract for its cash surrender value, and specifically authorizes and approves this action.

The undersigned represent(s) that the policy or contract is not subject to any prior assignment; that the policy or contract is not subject to proceedings in bankruptcy, federal tax levy, or collection proceedings resulting from an unpaid assessment, or any other legal action; and that there is no outstanding loan on the policy or contract.

The undersigned represent(s) and agree(s) that American General Life is furnishing this form and is participating in the transaction at the specific request of the undersigned and as an accommodation to the undersigned. The undersigned represent(s) and agree(s) that American General Life makes no representation concerning the undersigned's tax treatment under Internal Revenue Code Section 1035 or otherwise, and that American General Life has no responsibility or liability for the validity of the assignment.

The undersigned acknowledge(s) that this assignment is not effective until accepted in writing by American General Life.

For ALL 1035 Exchanges, please provide the cost basis information for the current policy.

d. Nonqualified (NQ) Fund Transfer (NOT ELIGIBLE FOR SECTION 1035 EXCHANGE)

Transfer From (check one):
☐ NQ Certificate of Deposit
☐ NQ Mutual Fund
☐ Other NQ Funds that are not Section 1035 Exchange_____

Transfer To: (check one):
☐ Nonqualified Annuity Policy
☐ Nonqualified Life Insurance Policy

The funds transfer may be taxable. Complete Tax Withholding Election and Representation section 4c.

---

4. LIQUIDATION INSTRUCTIONS for Current Company - The surrendering institution is requested to

a. Liquidate / surrender

☐ Entire account / contract / policy Approximate Value $ _____
☐ Partial liquidation $ _____ or _____%
☐ Immediately
☐ At maturity date of _____

b. Required Minimum Distribution (must specify if Qualified Funds and Owner is $70^1/_2$ or older)

If I am $70^1/_2$ or older, do not transfer or roll over my current year's required minimum distribution (RMD). I direct the present custodian/trustee to (check one):

☐ **Proceed with the transfer as I have already taken my current year's RMD.**
☐ **Distribute my RMD to me before transferring my funds.** Complete Tax Withholding Election and Representation section 4c below.

c. Tax Withholding Election and Representation for

- Surrender of Nonqualified Life or Annuity Policy NOT Eligible for Section 1035
- Conversion to Roth IRA
- RMD Distribution
- IRA to NQ Policy

INCOME TAX WITHHOLDING ELECTION

If no election is made, or if withholding is required by law notwithstanding your election(s), applicable taxes will be withheld in accordance with federal and state law.

Federal Election – If your payments of estimated tax are inadequate and sufficient amount of tax is not withheld from any distribution, penalties may be imposed under the estimated tax payment rules.

☐ I elect **not** to have federal income tax withheld from the **taxable portion** of my distribution check.
☐ I elect to have federal income tax withheld from the **taxable portion** of my distribution check, reducing the indicated amount by the amount withheld.

☐ Amount to be deducted _____ or ☐ Percentage to be deducted _____.

State Election – State laws may require additional documentation in order to opt out of state income tax withholding or to designate an amount to be withheld. Contact your appropriate state taxing authority for more information.

☐ I elect **not** to have state income tax withheld from the **taxable portion** of my distribution check.
☐ I elect to have state income tax withheld from the **taxable portion** of my distribution check, reducing the indicated amount by the amount withheld.

☐ Amount to be deducted _____ or ☐ Percentage to be deducted _____.

REPRESENTATION

I (We) represent to the Company that no Bankruptcy or insolvency proceedings have been instituted by or against me (us), that no party (other than the Company) has a claim against the Policy, and that no assignment of the Policy, other than previous assignments recorded by the Company, is now in effect

Certification: Under penalty 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),**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service 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. person (including a U.S. resident alien).**

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 of underreporting interest or dividends on your tax return.

5. TRANSACTION AUTHORIZATION

I request that the above referenced contract/policy/account be cash surrendered and/or liquidated. I request the surrendered/liquidated funds be transferred to American General Life. I am aware of any penalties or surrender charges that will result from this liquidation by the previous company. I am further aware that any tax consequences of this transaction are solely my own and that I may wish to consult my tax advisor.

No American General Life agent has undertaken to give me investment, tax, or legal advice with respect to my purchase of an IRA, non-qualified annuity, or life insurance policy. I understand that I should seek independent counsel as to investment, tax, and legal issues raised by this transaction.

I hereby authorize American General Life to rely upon the information provided by the current insurer, trustee, or custodian, and to assume, in the absence of such information, that more restrictive and/or less beneficial tax rules apply to the amounts transferred.

No coverage that the Company elects to issue will be deemed to have taken effect with American General Life solely because of the assignment of any insurance policy or annuity contract described above or because of a request to transfer to American General Life funds described above. A policy or contract shall be deemed issued by American General Life in exchange for a policy contract of another insurer or in exchange for other funds transferred to American General Life when American General Life approves the application and American General Life receives the cash surrender value of a policy or contract or receives such other funds and such cash surrender value or funds are equal to at least one modal premium or one monthly deduction of costs of insurance and other charges, as the case may be. Any temporary insurance under a conditional receipt delivered to me shall be subject to the terms of such receipt. If a claim should arise before American General Life receives requested cash surrender value of another insurer's insurance policy or annuity contract, any claimant will look to the other insurer and not to American General Life for benefits.

ALL REQUESTS REQUIRE WITNESSED SIGNATURE(S)

Dated at _____ this _____ day of _____ , 20_____.
City and State

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

_____ _____ | | | | | | | | | |
Non-Related Witness or Notary Signature for Owner — Signature of Owner or Plan Participant — Social Security Number

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

_____ _____ | | | | | | | | | |
Non-Related Witness or Notary Signature for Co-Owner — Signature of Co-Owner (if any) — Social Security Number

_____ _____
Non-Related Witness or Notary Signature for Spouse — Signature of Spouse (if required by law)

_____ _____
Non-Related Witness or Notary Signature for Irrevocable Beneficiary — Signature of Irrevocable Beneficiary (if any)

_____
Medallion Signature (if required by Current Company)

FOR OFFICE USE ONLY

6. ACCEPTANCE (TO BE COMPLETED BY AMERICAN GENERAL LIFE)

The above named individual has established or applied for a(n):

☐ Individual Retirement Annuity ☐ Simplified Employee Pension (IRA) ☐ Roth Individual Retirement Annuity
☐ Non-qualified Annuity ☐ Life Insurance Policy

The authorized signature below certifies acceptance of assignment and surrender or transfer of funds as instructed in this request.

Assignee / Successor Custodian: American General Life Insurance Company

By:_____ _____
Signature of Authorized Company Representative Date

7. INSTRUCTIONS TO CURRENT ISSUER, CUSTODIAN OR TRUSTEE

a. Please see sections 5, 6 and 7 for Authorization, Acceptance Notification, Check Preparation and Mailing information
b. Please make check payable to

American General Life Insurance Company

FBO:_____

SSN or Contract No.: _____

c. Please mail check to

American General Life Insurance Company
American General Center - 400S
Nashville, TN 37250-0001

REFERENCE INFORMATION
- **Trustee-to-Trustee Transfers**
- **Conversion to Roth IRA**

Existing Plans May be Rolled Over, Transferred, or Converted into New IRA per Chart Below

Existing IRA / Retirement Plan		May Go To:
Transfer / Direct Rollovers of Existing IRA Plans	Traditional IRA	Traditional IRA, SEP IRA
	Roth IRA	Roth IRA
	SEP IRA	SEP IRA, Traditional IRA
	Simple IRA - established within past 2 years	Simple IRA (American General Life does not offer Simple IRAs)
	Simple IRA - established more than 2 years ago	Traditional IRA, SEP IRA Simple IRA (American General Life does not offer Simple IRAs)
Eligible Rollover distributions from Employer Plans	Eligible distributions from • Employer's Qualified pension, profit-sharing or stock bonus plan, or annuity plan • Tax-sheltered annuity plan (section 403(b) plan) • Governmental deferred compensation plan (section 457 plan) • Keogh Plan (HR-10)	Traditional IRA, SEP IRA
Conversions Tax Consequences: When converting an existing IRA into a Roth IRA, the value is includible in your income as a taxable distribution.	Conversions from • Traditional IRA • SEP IRA • SIMPLE IRA	Roth IRA

For more information on rollovers, transfers, and conversions, please see IRS Publication 590 — Individual Retirement Arrangements (IRAs)

American General Life Insurance Company
American General Center
Nashville, TN 37250-0001

Financial Questionnaire

Proposed Insured

Please complete questions 1 through 4 for personal insurance or questions 1 through 11 if the insurance is for business purposes, then date and sign the questionnaire.

Proposed insured _____ Date of birth _____ Social Security # _____

1. Your income (before Income Tax):

	Current fiscal year (Date / / thru / /)	Previous fiscal year
Salary or wages		
Bonuses and/or commissions		
Net business or professional income (i.e., Gross income less business expenses, but not before personal income)		
Other earned income *(give details in "Remarks" below)*		
Unearned income (interest and dividends, not real estate income, etc.) *give details in "Remarks" below)*		
TOTAL		

2. What is your approximate net worth, i.e., assets minus liabilities? (if necessary, give details in "Remarks" below)

	Current fiscal year (Date / / thru / /)	Previous fiscal year
Personal Assets		
Business Assets		
Liabilities		
Net worth		

3. Estimated tax liabilities at death (include potential estate taxes, inheritance taxes and capital gains taxes, both federal and state)

_____

_____

4. How was the need for this new amount of coverage determined?

_____

_____

Remarks (questions 1-4) _____

_____

_____

SIGNATURE REQUIRED ON BACK.

5. Purpose of business insurance

❑ Key Executive ❑ Loan Coverage ❑ Buy-Sell Agreement/Stock Repurchase ❑ Other

Other purpose — explain: _____

_____

6. Is there a written buy/sell agreement in effect? (if yes, attach copy) ❑ Yes ❑ No

Is there a buy/sell agreement contemplated? ❑ Yes ❑ No

7. Creditor: Name of lender _____

Is insurance requested by lender? ❑ Yes ❑ No

Coverage amount required by creditor: _____

Purpose of loan _____

_____

(Use "Remarks" below for further details.)

8. Are other corporate officers or partners being insured? ❑ Yes ❑ No

If yes, give details, if no, explain: _____

_____

9. a. What percentage of the business do you own? _____% 9b. Date business started _____

10. Estimated fair market value of business: _____

(In "Remarks" state how this value was determined)

11. Financial details of business:

	Current fiscal year (Date / / thru / /)	Previous fiscal year
A. Total assets		
B. Total liabilities		
C. Gross sales or revenue		
D. Net income (before taxes)		

Please submit a copy of the most recent balance sheet and income statement (year or quarter).

Remarks (questions 5-11) _____

_____

_____

Agreement: All statements in and answers to this questionnaire are full, complete and true to the best of my knowledge and belief, and are a continuation of, and form a part of, the application for insurance.

X Owner _____ Date _____

(If other than Proposed Insured)

Signed at (City, State) _____

X Witness _____ Date _____

X Proposed Insured _____ Date _____

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

www.qualityoflifeinsurance.com

American General Life Insurance Company
American General Center • Nashville, TN 37250-0001