TOOLS & TIPS • tip sheets •

Tips for Accelerated Application & Compliant Replacement Processing

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

Coversheet/Transmittal – Please provide:

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

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

- Correct state version of application and all forms required. Should match the state in which the owner has signed.
- Name, address and date of birth
- Social Security number (insured and owner SSN needed, if different parties)
- Birthplace
- All tobacco use questions answered completely
- Driver's license number and state, if applicable; Questions must be answered if applicant is over 16 years of age
- All employer and employment information
- All income specified
- Citizenship information
- Owner information, if different than applicant
- Beneficiary information
- Entity Information / Trust ID for owner
- Plan name and term, if applicable
- Face amount for insured, any riders requested, and Premium Class Quoted
- Premium frequency, mode, and method
- Bank draft and/or void check provided for monthly payment, if applicable
- Initial Premium Received – if yes, Limited Temporary Life Insurance (LTLIA) may be applicable; See Other Forms section below.
- All payor information including SSN, if payor different than applicant/owner
  - If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form
- All replacement information must be received
  - Existing coverage, (insuring) company name and face amount
  - NAIC replacement form for NAIC states is other coverage exists
  - Correct state required replacement form(s) received, must be signed and dated on or before the Part A
  - Refer to the Replacement Section of this form for additional, more detailed information.
- All background information questions answered with complete details or applicable questionnaires provided for any "Yes" answers
- Signatures of Insured & Owner (if owner is different than insured)
- City/State/Date of signing
- Agent's signature
- All pages of application and supplemental forms (see below for more info on commonly needed forms)

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

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

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

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

Existing Coverage Information

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

Replacement Information

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

1035 Information

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

Existing Coverage and Replacements

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

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

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

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

Notice Regarding Replacement

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

Reminders:

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

Individual Life Insurance Application
Single Insured – Part A

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

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

1. Primary Proposed Insured

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

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

First Name_____ MI____ Last Name _____ Gender ☐ M ☐ F
SSN _____ DOB _____ Relationship to Proposed Insured _____
Driver's License ☐ yes ☐ no License State _____ Number _____
U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship _____ Date of Entry_____
Visa Type_____ Exp. Date _____
Address _____ City_____ State _____ ZIP_____
Primary Phone _____ Email_____
(If contingent Owner is required, use question 12.)

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

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

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

**for identification purposes only*

5. Entity Information - *Complete if Owner or Beneficiary is a business, charitable entity or trust. If applicable, complete the Certification of Trust.*
(Check the applicable boxes information applies to: ☐ Owner and/or ☐ Beneficiary If also the Premium Payor, complete section 9E.)
Exact Name_____ Tax ID #_____
Address _____ City_____ State _____ ZIP_____
Current Trustee Name _____ Date of Trust _____
Corporate Officer Nam _____ Title _____
Email Address of applicable Trustee or Corporate Signer_____
Relationship to Proposed Insured _____ Type of Entity (SCorp, CCorp , DBA, etc.)_____

6. Product - *Signed Illustration/Quotation is required for all UL & VUL products.*
Plan Name (Complete appropriate supplemental application if applicable. For Index UL, complete the Index UL Supplemental Application.)
_____
Term Duration** _____ Premium Class Quoted _____
Amount Applied For: Base Coverage $ _____ Supplemental Coverage** $_____
Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation | Automatic Premium Loan**: ☐ yes ☐ no

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

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

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

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

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

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

B. Method: ☐ Direct Billing ☐ Bank Draft (Complete Bank Draft Authorization) ☐ List Bill: Number_____
☐ Credit Card - Initial Premium Only (Complete Credit Card Authorization) ☐ Other (Please explain) _____

C. Amount submitted with application $_____

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

E. Premium Payor *(Complete if Payor is other than Owner or if Owner is Trustee.)*
First Name _____ MI ____ Last Name _____ Gender ☐ M ☐ F
SSN or Tax ID #_____ Relationship to Primary Proposed Insured _____
Driver's License ☐ yes ☐ no License State _____ Number_____ DOB_____
U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship_____ Date of Entry _____
Visa Type _____ Exp. Date_____
Address_____ City _____ State_____ ZIP_____
If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form.

10. Existing Coverage and Replacements

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

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

***Complete only if applicable*

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

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

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

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

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

_____

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

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

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

_____

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

_____

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

_____

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

_____

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

_____

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

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

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

_____

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

_____

_____

_____

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured (and any Owner signing below) acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

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

If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the conditions set forth in the LTLIA are met. I understand and agree that such temporary insurance is not available as to any riders or any accident and/or health insurance.

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

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

I authorize any medical professional; any hospital, clinic or other health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; the MIB, LLC (MIB); or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability, or that of any minor child for whom application for insurance is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information concerning me, or any minor child for whom application for insurance is being made. Other information may include, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this application. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931. This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company, its affiliated insurers, and its affiliated service companies to obtain an investigative consumer report on me. I understand that I may: (1) request to be interviewed for the report; and (2) upon written request, receive a copy of such report.

☐ Check if you wish to be interviewed.

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

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

Owner Signature

X

Owner Title _____

(If Corporate Officer or Trustee)

Owner signed at (city, state) _____

Owner signed on (date)_____

Primary Proposed Insured Signature (if other than Owner)

X

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

Agent(s) Signature(s)

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

Writing Agent Name *(please print)*_____

Writing Agent # _____

Writing Agent Signature **X** _____

Other Parent or Guardian Signature

X

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

Agent's Report

Policy # (if known): _____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #

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

2. Does any Proposed Insured(s) have any existing or pending annuities or life insurance policies? *(If yes, certain states require completion of replacement-related forms even when other life insurance or annuities are not being replaced by the policy being applied for - please attach such forms.)*..... ☐ yes ☐ no

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

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

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

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

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

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

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

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

_____

_____

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

_____

_____

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

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

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

11. Agent Agreement and Signature

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

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

Writing Agent Signature **X** _____

State License # _____ Phone # _____

Email _____ Fax # _____

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

_____ _____/_____/_____

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

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

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

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

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

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

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

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

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P.O. Box 9000, Amarillo, TX 79105-9000. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

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

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

MIB ACKNOWLEDGEMENT

I also authorize the Company, its reinsurers or authorized third party administrators to make a brief report to MIB.

Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X

Signed on (date) _____

Signor name (printed) _____

Relationship _____

Description of Authority of Personal Representative

(if applicable) _____

_____

Control Number/Policy Number_____

_____

Bank Draft Authorization

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

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

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

PAYMENT OPTIONS: Please select ONLY one payment option:

☐ Draft Initial Premium and Draft Subsequent Premiums

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

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

Subsequent Premiums, if different: $_____.___

☐ Draft Only Subsequent Premiums

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

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

DRAFT DETAILS: Please provide the requested details.

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

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

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

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Type of Account: ☐ Checking ☐ Savings

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

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

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

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

Email Address 1 _____

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

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

Email Address 2 _____

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

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

Street _____ City _____ State _____ ZIP _____

AGREEMENT:

I (we) hereby authorize and request the Company or its representative to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) understand that this Authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment in its Service Center.

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

I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request must be dated and signed by the Bank Account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Signature of Bank Account Owner

X _____

Date _____

Signature of Bank Account Owner, if joint account

X _____

Date _____

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

LEAVE THIS FORM WITH THE PROPOSED INSURED(S)

NOTICES TO THE PROPOSED INSURED(S)

American General Life Insurance Company, Houston, TX

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

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

FAIR CREDIT REPORTING ACT

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.

MIB, LLC

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), which operates an information exchange on behalf of its members of MIB Group, Inc. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

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

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

INSURANCE INFORMATION PRACTICES

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

You have the right to access and, if necessary, correct, amend, or delete personal information, except information that relates to a claim or a civil or criminal proceeding. This requires a written request to access your personal information and to request correction, an amendment, or deletion. We do not have to change our records if we do not agree with your request, but we will place your statement in our file. You have the right to receive a response within 30 business days of submitting a request to access, correct, amend, or delete your personal information.

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

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

TELEPHONE INTERVIEW INFORMATION

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

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

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

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

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

Limited Temporary Life Insurance Agreement (Agreement)

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

1. Check appropriate Company:

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

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

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

Primary Proposed Insured _____

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

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

Modal Premium Amount Received _____

Date of Policy Application _____

3. Answer the following questions:

	Yes	No
a. Has any Proposed Insured ever been diagnosed with, or sought treatment from a member of the medical profession for any of the following: a heart attack; stroke; coronary artery disease or other heart disease; cancer; diabetes; or disorder of the immune system, including but not limited to Acquired Immune Deficiency Syndrome (AIDS) or infection by the Human Immunodeficiency Virus (HIV)?	☐	☐
b. Has any Proposed Insured, during the last two years: (1) been confined in a hospital or other health care facility (except for childbirth without complications); (2) received medical treatment or counseling for alcohol or drug use; or (3) been advised to have any diagnostic test or surgery not yet performed (except for those tests related to the Human Immunodeficiency Virus (HIV))?	☐	☐
c. Is any Proposed Insured either less than 14 days old or over age 70 1/2?	☐	☐

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

4. Complete and sign this section:

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

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

Owner Signature

X _____

Owner signed on (date)_____

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

X _____

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

PPI signed on (date) _____

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

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

X _____

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

OPI signed on (date) _____

Writing Agent Name (please print) _____

Writing Agent # _____

TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT

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

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

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

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

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

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

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

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

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

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

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

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- $1,000,000 plus the amount of any premium paid for coverage in excess of $1,000,000 ; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

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

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

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

(Complete separate Part B for each Proposed Insured.)

First Name	MI	Last Name	Date of Birth	Social Security #

Medical History

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

1. Physician Information

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

Name _____ Phone _____

Address _____ City, State _____ ZIP _____

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

_____

_____

_____

_____

2. Pending Medical Appointments

Does the Proposed Insured have a medical appointment scheduled within the next three months? ..... ☐ yes ☐ no

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

_____

_____

3. Build

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

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

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

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

4. Family History

A. Complete the information in the grid below.

Age if Living	Age at Death	Cause of Death	History of heart disease treated or diagnosed by a member of the medical profession (Coronary Artery Disease or Heart Attack)?	History of cancer treated or diagnosed by a member of the medical profession?
Father _____	_____	_____	☐ no ☐ yes Age of Onset _____ Details _____	☐ no ☐ yes Age of Onset _____ Type _____
Mother _____	_____	_____	☐ no ☐ yes Age of Onset _____ Details _____	☐ no ☐ yes Age of Onset _____ Type _____
Siblings_____	_____	_____	☐ no ☐ yes Age of Onset _____ Details _____	☐ no ☐ yes Age of Onset _____ Type _____

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

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

Details: _____

_____

C. Is there a family history (parents and siblings only) of mental illness, suicide, or substance abuse, any of which was diagnosed or treated by a member of the medical profession? ☐ yes ☐ no

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

Details: _____

_____

5. Personal Health History

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

1) high cholesterol? ☐ yes ☐ no

Date of diagnosis _____ most recent level _____treatment _____

2) high blood pressure? ☐ yes ☐ no

Date of diagnosis _____ most recent reading _____treatment _____

3) diabetes? ☐ yes ☐ no

Date of diagnosis _____ most recent HgbA1c _____treatment _____

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

1) coronary artery disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, or other disorder or disease of the heart? ☐ yes ☐ no

2) blood clot, clotting disorder, aneurysm, stroke, transient ischemic attack (TIA), peripheral vascular disease, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☐ no

3) cancer, leukemia, lymphoma, tumors or growths, masses, cysts or other similar abnormalities? ☐ yes ☐ no

4) pituitary, thyroid, adrenal, or disease or disorder of any other glands? ☐ yes ☐ no

5) anemia, hemophilia, sickle cell anemia, or other disease or disorder of the blood, lymphatic system or immune system? ☐ yes ☐ no

6) colitis, Crohn's disease, hepatitis, colon polyps, or any disorder of the throat, esophagus, gall bladder, stomach, liver, pancreas or intestine? ☐ yes ☐ no

7) disorder of the kidneys, bladder, prostate or reproductive organs or protein or blood in the urine? ☐ yes ☐ no

8) asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea or other breathing or lung disorder? ☐ yes ☐ no

9) seizures, cerebral palsy, Down syndrome, autism spectrum disorder, Parkinson's disease, multiple sclerosis, severe headaches, disorder or injury of the brain, spinal cord or nervous system? ☐ yes ☐ no

10) attention deficit hyperactivity disorder (ADHD), memory loss, dementia or Alzheimer's disease? ☐ yes ☐ no

11) anxiety, eating disorder, depression, suicide attempt, bipolar disease, post-traumatic stress disorder (PTSD), hallucinations, psychosis, schizophrenia, or other psychiatric conditions? ☐ yes ☐ no

12) arthritis, muscle disorders, Amyotrophic Lateral Sclerosis (ALS), fibromyalgia, muscular dystrophy, chronic pain, connective tissue disease, autoimmune disease or other bone or joint disorders? ☐ yes ☐ no

13) glaucoma, macular degeneration, optic neuritis or any disorder of the eyes, ears or skin? ☐ yes ☐ no

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

Details_____

_____

_____

_____

_____

_____

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

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

Details_____

_____

_____

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

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

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

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

1) used cocaine, heroin, methamphetamine, hallucinogens, stimulants or any other habit-forming drug except as prescribed by a medical professional? ☐ yes ☐ no

2) used marijuana (prescribed or otherwise) in any form? ☐ yes ☐ no

3) used a controlled substance or prescription drug in a manner other than prescribed by a physician? ☐ yes ☐ no

4) sought or received medical advice, counseling or treatment by a medical professional to discontinue or reduce the use of alcohol or drugs, including prescribed controlled substances? ☐ yes ☐ no

If answered "Yes" to E1 through E4, please provide details below.

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

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

Name(s) of doctor/facility _____ Phone _____

Address _____ City, State _____ ZIP _____

Treatment Dates _____

Support group(s) _____

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

Details of any drug or alcohol related arrests _____

F. Has the Proposed Insured **ever** tested positive for the Human Immunodeficiency Virus (HIV) or been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☐ no

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

Details_____

_____

_____

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

1) been hospitalized, consulted a member of the medical profession or had any illness, injury or surgery? ☐ yes ☐ no

2) been advised by a member of the medical profession concerning any abnormal diagnostic test results, been advised to see a specialist, or been advised to have any diagnostic test, hospitalization, surgery, or treatment that was NOT completed (except for those tests related to the Human Immunodeficiency Virus), or does the proposed insured have any test results pending? ☐ yes ☐ no

3) undergone any self-administered laboratory test prescribed by a member of the medical profession other than those for pregnancy or Human Immunodeficiency Virus (HIV)? ☐ yes ☐ no

4) made a claim for or received benefits, compensation, payment or pension for any injury, sickness, disability, or impaired condition? ☐ yes ☐ no

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

Details_____

_____

_____

_____

_____

_____

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

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

Details_____

_____

_____

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

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

Details_____

_____

_____

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

1) been diagnosed or treated 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? ☐ yes ☐ no

2) received home health care services, physical therapy or rehabilitation therapy? ☐ yes ☐ no

3) required the use of a cane, walker, wheelchair, other assistive device, or resided in an assisted living facility? ☐ yes ☐ no

4) required assistance or supervision with or had any limitations in performing any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)? ☐ yes ☐ no

5) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside of the home or preparing meals? ☐ yes ☐ no

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

Details_____

_____

_____

K. Within the **last 5 years** has the Proposed Insured been treated for or been diagnosed by a member of the medical profession for any other medical, physical, or psychological condition **NOT** disclosed above? ☐ yes ☐ no

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

Details_____

_____

_____

Agreement and Signatures

I, the Proposed Insured signing below, acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Fraud

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

SIGNATURE OF PROPOSED INSURED

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

X _____

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

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

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

If Agent recorded information

_____ _____ _____

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

X _____

Writing Agent Signature

If Tele-interviewer recorded information

_____ _____ _____

Name *(Please print)* | Company | Date

If Paramedical Examiner/Medical Doctor recorded information

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

Examiner Phone # _____

Examiner Name _____

X _____ Date _____

Examiner Signature

EXAMINATION
Physical Measurements

1. Proposed Insured

A. _____ _____ _____
First Name MI Last Name

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

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

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

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

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

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

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

E. Examiner observations and remarks

1) Is appearance unhealthy or older than stated age?..... ☐ yes ☐ no
2) Are there any obvious physical abnormalities?..... ☐ yes ☐ no
3) Did anyone assist the Proposed Insured in answering any questions?..... ☐ yes ☐ no
4) Does Proposed Insured use any device to aid in locomotion (e.g. cane, walker, wheelchair)? ..... ☐ yes ☐ no
5) Does Proposed Insured use any other assistive device not previously disclosed (e.g. oxygen, prosthetic limb)? ... ☐ yes ☐ no
6) Does Proposed Insured seem confused, disoriented or otherwise impaired?..... ☐ yes ☐ no
7) Does Proposed Insured have any speech difficulties or use a voice prosthesis?..... ☐ yes ☐ no
8) Was this appointment conducted in a language other than English? (if yes, indicate language and who provided interpretation or translation services) ..... ☐ yes ☐ no
9) Do you have any pertinent information or observation not previously disclosed? ..... ☐ yes ☐ no

Details_____
_____
_____

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

Report By Examining Medical Doctor

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

1) Heart
   a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? ..... ☐ yes ☐ no
   b. Is heart enlarged? *(If yes, describe)*_____ ☐ yes ☐ no
   c. Is murmur present? *(If yes, complete question d)*..... ☐ yes ☐ no
   d. Murmur is:
      ☐ Constant Transmitted to where?_____
      ☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere
      ☐ Systolic *(Give details)* _____
      ☐ Diastolic Murmur grade: *(Please circle)* 1/6 2/6 3/6 4/6 5/6 6/6
      After valsalva, murmur is:
      ☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

Your impression _____
_____
_____

Report by Examining Medical Doctor *(continued)*

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

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

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

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

Details_____

_____

_____

Signature

Paramedical Examiner/Medical Doctor Signature

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

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

Examiner Address _____

Examiner Phone # _____

Examiner Name _____

Examiner Signature **X** _____

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

Addendum to Application
Policy # (if known): _____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

This addendum is part of the application to which it is attached. Addendum to *(Part A, Part B, etc.)* : _____

Primary Proposed Insured

First Name _____ MI ____ Last Name _____ SSN _____

(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)

Primary Proposed Insured (PPI) Signature

X

PPI signed on (date) _____

Other Proposed Insured (OPI) Signature

X

OPI signed on (date) _____

Owner Signature

X

(If other than Primary Proposed Insured)

Owner signed on (date) _____

HIV Testing and Consent
Texas Version

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 28 Liberty Street, 45th Floor, New York, NY 10005-1400

Notice and Consent Form for HIV-Related Testing

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

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

Meaning of Positive Test Result. The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results. All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result. If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent. I have read and I understand this Notice and Consent for HIV-Related Blood Testing. I voluntarily consent to the collection of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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

Signature of Proposed Insured or Parent/Guardian

X

Date signed _____

Proposed Insured's name (printed) _____

_____

Proposed Insured's Address _____

_____

Submit this form with the application

Terminal Illness Rider Instruction Sheet

(For use with the Accelerated Death Benefit Form)

If the Terminal Illness Rider is not desired, please disregard this instruction sheet and attached form.

Eligibility for the Terminal Illness Rider varies by state.

The attached form is not required in any state not listed below.

Please use the following information for the following states:

AL, AR, CT, DC, IN, KS, LA, MA, MI, MN, MS, NC, OH, OK, OR, TX, VA, and WA.

- If the applicant is requesting the Terminal Illness Rider on any product that has this rider available, the attached form (AGLC202129-2023 or AGLC101954-MA) must be completed and submitted with the application packet.
- On the Part A, check the Terminal Illness box in the Rider / Benefit section.

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

Disclosure of Accelerated Death Benefits
(Also known as Terminal Illness Rider)

American General Life Insurance Company

Disclosure Statement For Accelerated Death Benefits Required At Time Of Application For Policy

Benefit Description
Accelerated benefit means the payment during the Insured's lifetime of a portion of the Insured's death benefit under the policy. The Terminal Illness Accelerated Death Benefit Rider provides you the option to request an accelerated benefit if the Insured is certified as having a Terminal Illness, subject to the provisions of the rider. A description of Terminal Illness is provided below.

Limitations of the Accelerated Benefit:
You may use the money you receive from the Terminal Illness Accelerated Benefit Rider for any purpose. Accelerated benefits under this rider are intended to qualify for favorable tax treatment. However, accelerated benefits payable under this rider COULD BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from this accelerated benefit product. Accelerated benefits do not and are not intended to qualify as long-term care insurance.

A. Consequences of This Benefit:
Receipt of accelerated benefits MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI"), or other government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

Effects of the benefit payment:
1. The accelerated benefit amount will be treated as a lien against the policy Death Benefit.
2. Interest will accrue daily on the accelerated benefit amount and will also be treated as a lien against the policy Death Benefit.
3. The combined liens and any loan balance will reduce the policy death benefit proceeds and limit the amount of policy value, if any, that is available for full or partial surrenders or future loans.
4. After payment of an accelerated benefit, any policy cost of insurance and fees or premiums, as the case may be, and rider premiums will not be reduced.

B. Medical Condition(s) Enabling Accelerating of Life Benefit:
Terminal Illness means a condition that a physician certifies will reasonably be expected to result in death in 24 months or less as specified in the Terminal Illness Accelerated Benefit Rider.

C. Option:
The Terminal Illness Benefit is a one time acceleration of up to 50% of the life insurance coverage amount under the base policy, but not to exceed $250,000. The amount payable will be reduced by the amount of any outstanding loans and accrued loan interest and an administrative fee not exceeding $500. The amount paid will never be less than the percentage of the policy life insurance coverage amount you requested to accelerate, multiplied by the current Cash Value of the policy minus any outstanding loans and accrued loan interest.

D. Premium for Accelerated Benefit:
NONE, there is no additional charge for the Terminal Illness Accelerated Benefit Rider.

Applicant's Signature

X

Agent's Signature

X

Applicant signed on (date) _____

Agent signed on (date) _____

Agent Instructions: Please provide a copy of this form to the applicant and retain a copy for yourself.

Summary of Premium Provisions

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019

This notice highlights important premium provisions of the life insurance plan that you are applying for.

The policy form issued under the plan will include a table of current life insurance premiums and maximum life insurance premiums for each policy year.

The annual (or modal) policy premium as shown on this policy is applicable only for the level guarantee period stated in the policy.

After the end of the level guarantee period, and any policy year thereafter, the Company reserves the right to change the current premiums. Such premiums will not exceed the applicable maximum premiums shown in the policy.

Any change in premium will:

1. be based on changes in the Company's expectations of future investment earnings, mortality persistency, administrative and maintenance expenses, premium taxes, corporate income taxes or interest rates;

2. take effect only on a policy anniversary and only after 30 days' prior notice to the owner; and

3. apply to all insureds with the same benefits and provisions who have the same date of issue, age at issue, sex and underwriting class.

No change in premium will occur due to any change in an insured's health, occupation or avocation.

I have read the foregoing summary of premium provisions.

Proposed Owner's Signature

X

The original of this form must accompany the application(s) for this plan.

Medical Records Request Form

P.O. Box 90503 • Amarillo, TX 79105-4003

REQUESTOR INFORMATION

Company Name _____ Date of Request _____

Address _____

City _____ State _____ Zip _____

Name of Contact Person at Company _____

Contact Person Email Address (required) _____

Contact Person Telephone # _____

APPLICANT INFORMATION

Policy Number _____ Applicant Name _____ DOB _____

NOTE: Policy must be declined, approved less than standard or submitted via AG Quick Ticket to obtain copy of APS, exam, EKG or lab slip.

Medical Records Requested and Authorization Information

Please check all that apply.

☐ Paramed and/or Medical Exam ☐ Labslip ☐ EKG

☐ Attending Physician Statement(s) Requested ***(REQUIRED)***

Doctor/Facility Name _____ Doctor/Facility Name _____

Doctor/Facility Name _____ Doctor/Facility Name _____

Doctor/Facility Name _____ Doctor/Facility Name _____

☐ Signed release authorization included with request ***(REQUIRED)***

☐ UPS Delivery Request (Available if paid by requestor; Default delivery method is first class USPS.)

UPS Billing Acct Number _____

Select UPS Delivery Option

- ☐ Overnight by 10:30 am
- ☐ 2nd Day Delivery
- ☐ Other _____

MEDICAL RECORD SHIPPING INFORMATION (INTERNAL CONTROL #88001020573)

Mail to: (Info provided must match any mailing instructions provided on the client signed Release Authorization.)

Company Name _____

Attention _____

Address _____

City _____ State _____ Zip _____

OTHER SPECIAL INSTRUCTIONS

Medical Records Release Authorization

P.O. Box 90503 • Amarillo, TX 79105-4003

APPLICANT INFORMATION

Policy Number _____ Applicant Name _____ DOB_____

The purpose of this form is to provide your agent, agency, or insurance representative with permission to obtain a copy of all medical records previously obtained by American General Life Insurance Company (The United States Life Insurance Company in the City of New York, for NY applications only) ("the Company") in connection with your application for life insurance.

AUTHORIZATION/INSTRUCTION

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents, agencies and insurance support organizations, (collectively, the "Recipient"), the following information.

_____

Agent, Agency, or Insurance Representative to Receive Medical Record(s)

_____

Street Address

_____ _____ _____

City State Zip

I understand the disclosed information may be used by the above named individual or entity to determine eligibility for insurance with the Company or a third-party carrier not affiliated with the Company. I further understand that the Company has no responsibility or liability for the above named individual or entity's use or additional disclosure of the disclosed information.

I, as well as my representative, may, upon written request, obtain a copy of this consent from the Company. I agree that a photocopy of this consent will be as valid as the original.

The consent will be valid for 24 months from the date it is signed. I understand I may at any time write to the Company to revoke this authorization and that the revocation will take effect when the Company receives my written request, except to the extent that action has been taken in reliance on this authorization.

I have read the above statements or they have been read to me.

Signature of the Primary Proposed Insured Authorizing Disclosure or Primary Proposed Insured's Legal Representative

Signature of Primary Proposed Insured

X

Date Signed_____

Address _____

_____

Notice Regarding Replacement

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

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

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

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

Applicant's Signature

X _____

Applicant signed on (date) _____

Applicant's name (printed) _____

Producer's Signature

X _____

Producer signed on (date) _____

Producer's name (printed)_____

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

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

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

Make sure you know the facts. Contact your existing company or its agent 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 agent 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 agent 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 agent 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 refund according to its terms.

Applicant's Signature

X _____ _____ _____

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

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

X _____ _____ _____

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

Bank Draft Authorization

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

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

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

PAYMENT OPTIONS: Please select ONLY one payment option:

☐ Draft Initial Premium and Draft Subsequent Premiums

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

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

Subsequent Premiums, if different: $_____.___

☐ Draft Only Subsequent Premiums

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

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

DRAFT DETAILS: Please provide the requested details.

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

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

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

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Type of Account: ☐ Checking ☐ Savings

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

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

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

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

Email Address 1 _____

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

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

Email Address 2 _____

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

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

Street _____ City _____ State _____ ZIP _____

AGREEMENT:

I (we) hereby authorize and request the Company or its representative to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) understand that this Authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment in its Service Center.

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

I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request must be dated and signed by the Bank Account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Signature of Bank Account Owner

X _____

Date _____

Signature of Bank Account Owner, if joint account

X _____

Date _____

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

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019

SUMMARY AND DISCLOSURE NOTICE FOR TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

Receipt of a benefit under an 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 Terminal Illness Accelerated Death Benefit Rider. 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 any accelerated death benefit rider that is included in the policy. It is also important to carefully read any accelerated death benefit rider included in the policy.

TAX CONSEQUENCES

The Terminal Illness Accelerated Death Benefit Rider is intended to qualify for favorable tax treatment. However, accelerated death benefits payable under an accelerated death benefit rider MAY BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated death benefit rider.

BENEFIT DESCRIPTIONS

Accelerated benefit means the payment, during the Insured's lifetime, of the Insured's death benefit under the policy as described in an accelerated death benefit rider. The Terminal Illness Accelerated Death Benefit Rider described in this summary provides that the Owner may elect an accelerated benefit if the Insured experiences a covered qualifying event, subject to the provisions of the rider. The covered qualifying event is described below.

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

The Terminal Illness Accelerated Death Benefit Rider provides that the Owner may elect an accelerated death benefit if the Insured is diagnosed as having a Terminal Illness, subject to the provisions of the rider. Terminal Illness means an illness that is expected to result in the death of the Insured in 12 months or less from the date of the request for the accelerated death benefit.

BENEFIT AMOUNT FOR TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

The accelerated death benefit that is eligible to be paid under the Terminal Illness Accelerated Death Benefit Rider is equal to:

1. The Death Benefit Proceeds described in the policy; less
2. A percentage of the Death Benefit Proceeds shown in the rider; less
3. An administrative fee, not to exceed the Maximum Administrative Fee shown in the rider.

You may only elect to receive the entire terminal illness accelerated death benefit. This amount is paid to You in a lump sum.

EFFECT OF TERMINAL ILLNESS ACCELERATED DEATH BENEFIT PAYMENT ON POLICY

The policy will terminate if the terminal illness accelerated death benefit is paid. The death benefit proceeds, cash value and all other policy values will be equal to zero.

LIMITATIONS

Any accelerated death benefit will be subject to the following limitations:

1. The benefit is not intended to allow third parties to cause You to involuntarily access the policy proceeds payable to the named beneficiary. Therefore, the accelerated death benefit will not be available if You are required to request it for any third party, including any creditor, governmental agency, trustee in bankruptcy or any other person or as the result of a court order.
2. If the Insured dies after a request for an accelerated death benefit has been submitted and before You receive the accelerated death benefit payment, such request will be voided and the policy's death benefit proceeds will be payable, subject to all other policy provisions.

MEDICAID/GOVERNMENT BENEFITS

Receipt of accelerated death benefits from a life insurance policy MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI"), OR OTHER GOVERNMENT PROGRAMS. In addition, exercising the option to accelerate the death benefit and receiving that benefit before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

IMPORTANT NOTICES

There is no premium or charge to include the Terminal Illness Accelerated Death Benefit Rider on a policy.

Accelerated benefits do not qualify and are not intended to qualify as long-term care insurance.

Agent Certification Form

☐ **American General Life Insurance Company**
☐ **The United States Life Insurance Company in the City of New York**

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Insured's Social Security Number _____ Policy Number _____

Additional Insured's Social Security Number_____

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

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

Non-Premium Financing Certification

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

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

Premium Financing Certification

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

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

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

Premium Financing Disclosure for Proposed Insureds

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019

In this form, the "Company" refers to the insurance company name listed above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

We are providing this notice to all insureds age 67 or older who have applied for life insurance policies, as we have seen unprecedented growth in premium financing for policies in this demographic.

Premium financing is a practice that has been used in connection with the sale of life insurance policies for many years. If you are contemplating financing the purchase of life insurance or participating in the acquisition of a life insurance policy acquired with funds from a source outside your control, please consider the following issues:

- All the questions on the life insurance application should have been answered accurately and completely. Misrepresentations about your health, your financial resources or the purpose for acquiring the policy may result in claims disputes rather than payment of insurance benefits.

- Be sure you understand the transaction. Some transactions are established with a trustee or other third party who obtains financing from a lender on terms that may not be to the insured's advantage. Ask yourself, are the parties involved looking out for your best interest?

- Will a significant portion of your policy death benefit reach your beneficiaries? If most of the death benefits are not going to your beneficiaries, perhaps you should consider acquiring a more affordable policy that you control for your beneficiaries.

IMPORTANT: Any payments received as an inducement for entering into a life insurance transaction are taxable as ordinary income. Also, if you have financed premiums to pay for a policy with the understanding that you can walk away after the initial term with no personal obligation to repay the loan or loan interest, it is possible that forgiveness of debt can also create taxable income for you. If you sell your policy the gain is taxable to you. You should consult with your personal tax advisor about any questions you may have regarding the tax consequences of this transaction.

- It is important to know the lender, the trustee or other parties participating in the transaction. Ask whether you are comfortable participating in a transaction where investors or entities you do not know may end up owning a large insurance policy on your life.

This is not a complete list of all the issues that you should consider when contemplating a new life insurance transaction. If you have any questions or concerns, you can contact your Agent or call our Company at 1-800-247-8837, prompt 1.

Please acknowledge that you have received this disclosure by signing a copy of this form and returning it to the Company. Retain a copy for your records.

Proposed Insured's Signature

X _____

Proposed Insured signed on (date) _____

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

_____ _____/_____/_____

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

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

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

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

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

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

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

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

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P.O. Box 9000, Amarillo, TX 79105-9000. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

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

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

MIB ACKNOWLEDGEMENT

I also authorize the Company, its reinsurers or authorized third party administrators to make a brief report to MIB.

Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X

Signed on (date) _____

Signor name (printed) _____

Relationship _____

Description of Authority of Personal Representative

(if applicable) _____

_____

Control Number/Policy Number_____

_____

INTERNATIONAL BROKERAGE AGENCIES, INC.

HIPAA AUTHORIZATION RELEASE
TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured

Please Print

_____ _____/_____/_____

First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer report agency, state motor vehicle agency, employer, or any other person or institution to release to each of the insurance companies listed below, as well as to their reinsures, any insurance support organizations, those person authorized to represent them; and International Brokerage Agencies, Inc.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- Aetna Companies
- Allstate Health Solutions
- American National
- APPS
- Brighthouse Life
- Corebridge
- ExamOne
- Express Imaging Services
- Fidelity Life
- Gerber
- Global Atlantic
- Illinois Mutual
- IMG
- J&H
- John Hancock
- Kemper
- Legal & General
- Lincoln Financial Group
- MassMutual
- Mutual of Omaha
- Nationwide
- North American
- OneAmerica
- Pacific Life
- Principal Life
- Protective
- Prudential
- SBLI
- Securian Financial
- Symetra
- Transamerica
- World Trips

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility or any other health care provider to release and disclose my entire medical record without restriction to International Brokerage Agencies, Inc. I understand that any information that it is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, disability income, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies listed above and their re-insurers as well as International Brokerage Agencies, Inc. and its staff, employees and affiliated companies.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall be valid for twenty-four (24) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand I may revoke this authorization in writing at any time by providing that written notification to International Brokerage Agencies, Inc. at the service address below. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand that if I refuse to sign this authorization, International Brokerage Agencies, Inc. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health services if I refuse to sign this authorization.

_____ _____

Signature of Proposed Insured Name of Proposed Insured

_____ _____ _____

City State Month/Day/Year

International Brokerage Agencies, Inc.
P.O. Box 1345, Joshua, TX 76058
Phone: (817) 752-4980; Fax: (817) 752-4982