

**APPLICATION FOR LIFE INSURANCE**  
**American General Life and Accident Insurance Company**  
 American General Center • Nashville, Tennessee 37250-0001

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

b. Address \_\_\_\_\_  
Street City State Zip Code Country

Birth Date and Place \_\_\_\_\_  
Month Day Year State Country

c. SSN: \_\_\_\_\_  
Country

d. Marital/Domestic Status:  Single  Married  Widowed  Divorced  Other \_\_\_\_\_

e. Driver's License No. \_\_\_\_\_ f. State of Issue \_\_\_\_\_  
 If over age 16 and no license, please explain. \_\_\_\_\_

g. Annual Earned Income \_\_\_\_\_ h. Other Sources of Income \_\_\_\_\_

i. Occupation \_\_\_\_\_ j. How long in occupation \_\_\_\_\_

k. Employer \_\_\_\_\_ l. Job duties \_\_\_\_\_

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

o. Is Primary Proposed Insured actively at work and able to perform all regular job duties?  Yes  No  
 If "No," explain: \_\_\_\_\_

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

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

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

b. Address \_\_\_\_\_  
Street City State Zip Code Country

Birth Date and Place \_\_\_\_\_  
Month Day Year State Country

c. SSN: \_\_\_\_\_  
Country

d. Marital/Domestic Status:  Single  Married  Widowed  Divorced  Other \_\_\_\_\_

e. Driver's License No. \_\_\_\_\_ f. State of Issue \_\_\_\_\_  
 If over age 16 and no license, please explain. \_\_\_\_\_

g. Annual Earned Income \_\_\_\_\_ h. Other Sources of Income \_\_\_\_\_

i. Occupation \_\_\_\_\_ j. How long in occupation \_\_\_\_\_

k. Employer \_\_\_\_\_ l. Job duties \_\_\_\_\_

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

o. Is Additional Proposed Insured actively at work and able to perform all regular job duties?  Yes  No  
 If "No," explain: \_\_\_\_\_

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

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

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

Full Name	Age	Birth Date			Gender	Relationship (If stepchild, consent required)	For any child under age one (including Primary Proposed Insured) Name: _____ Birth Weight _____ lbs. _____ oz. Weight Now _____ lbs. _____ oz.
		Month	Day	Year			
a. _____							
b. _____							
c. _____							
d. _____							

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

Address \_\_\_\_\_  
Street City State Zip Code

SSN/TIN: \_\_\_\_\_ Relationship to Primary Proposed Insured \_\_\_\_\_

**Home Office Use Only**

5. Premium Payor Name (If other than Primary Proposed Insured) \_\_\_\_\_  
 Address \_\_\_\_\_  
 Street City State Zip Code  
 SSN/TIN: \_\_\_\_\_ Relationship to Primary Proposed Insured \_\_\_\_\_

6. Complete for Primary Proposed Insured:

a. Plan Name \_\_\_\_\_ If Term: Duration \_\_\_\_\_ Ins Amount \$ \_\_\_\_\_  
 If Universal Life: Death Benefit  Option A  Option B

b. Benefits & Riders

<input type="checkbox"/> Waiver Rider	<input type="checkbox"/> Terminal Illness Rider
<input type="checkbox"/> Additional Insurance Option \$ _____	<input type="checkbox"/> Monthly Guarantee Premium Rider
<input type="checkbox"/> Accidental Death \$ _____	<input type="checkbox"/> Children's Term Rider \$ _____ Amt
<input type="checkbox"/> Single Premium Whole Life \$ _____	<input type="checkbox"/> Level Term Rider \$ _____ Amt
<input type="checkbox"/> Spouse Level Term Rider \$ _____ Amt	<input type="checkbox"/> Additional Insured Rider \$ _____ Amt
<input type="checkbox"/> Accelerated Benefit Rider 2 Initial Defined Benefit – Primary Proposed Insured <input type="checkbox"/> 5% <input type="checkbox"/> 10% <input type="checkbox"/> Other _____	<input type="checkbox"/> Additional Proposed Insured
<input type="checkbox"/> Accelerated Benefit Rider 2 Initial Defined Benefit – Additional Proposed Insured <input type="checkbox"/> 5% <input type="checkbox"/> 10% <input type="checkbox"/> Other _____	<input type="checkbox"/> Disability Income Rider 2
<input type="checkbox"/> Primary Proposed Insured	<input type="checkbox"/> Disability Income Rider 5
<input type="checkbox"/> Disability Income Rider 2	Monthly Benefit _____
<input type="checkbox"/> Disability Income Rider 5	Occ. Class _____
Monthly Benefit _____	<input type="checkbox"/> Other _____
Occ. Class _____	
<input type="checkbox"/> Other _____	

7. First Beneficiary \_\_\_\_\_  
 Name Relationship Age SSN/TIN  
 \_\_\_\_\_  
 Address \_\_\_\_\_

Secondary Beneficiary \_\_\_\_\_  
 Name Relationship Age SSN/TIN  
 \_\_\_\_\_  
 Address \_\_\_\_\_

8. Premium and Payment

a. Premium \$ \_\_\_\_\_ Lump Sum \_\_\_\_\_  1035 exchange

b. Payment Mode:  A  S  Q  M Planned Periodic Premium \_\_\_\_\_  
 Other \_\_\_\_\_

Automatic Bank Check  Add to existing ABC account, policy no. \_\_\_\_\_  
 AG Payroll Deduction (AGLA employees only)  New payroll account no. \_\_\_\_\_  
 Payroll Deduction  Add to existing PD account no. \_\_\_\_\_  
 Anticipated Effective Date of Coverage \_\_\_\_\_

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

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

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

9. a. Individual to be insured is the  Primary Proposed Insured or  Additional Proposed Insured listed on this application.  
 b. Plan Name \_\_\_\_\_ If Term: Duration \_\_\_\_\_ Ins Amount \$ \_\_\_\_\_ If UL: Death Benefit  Option A  Option B  
 c. Benefits & Riders  
 Waiver Rider  
 Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 9.a.  5%  10%  Other \_\_\_\_\_  
 Other \_\_\_\_\_  Other \_\_\_\_\_  
 d. If beneficiary is to be other than as listed in question 7 above, please complete the following:  
 First Beneficiary \_\_\_\_\_  

Name	Relationship	Age	SSN/TIN
_____	_____	_____	_____
Address			
_____			

 Secondary Beneficiary \_\_\_\_\_  

Name	Relationship	Age	SSN/TIN
_____	_____	_____	_____
Address			
_____			

 e. Premium \$ \_\_\_\_\_  Lump Sum \_\_\_\_\_  1035 exchange  Planned Periodic Premium \_\_\_\_\_

10. a. Individual to be insured is the  Primary Proposed Insured or  Additional Proposed Insured listed on this application.  
 b. Plan Name \_\_\_\_\_ If Term: Duration \_\_\_\_\_ Ins Amount \$ \_\_\_\_\_ If UL: Death Benefit  Option A  Option B  
 c. Benefits & Riders  
 Waiver Rider  
 Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 10.a.  5%  10%  Other \_\_\_\_\_  
 Other \_\_\_\_\_  Other \_\_\_\_\_  
 d. If beneficiary is to be other than as listed in question 7 above, please complete the following:  
 First Beneficiary \_\_\_\_\_  

Name	Relationship	Age	SSN/TIN
_____	_____	_____	_____
Address			
_____			

 Secondary Beneficiary \_\_\_\_\_  

Name	Relationship	Age	SSN/TIN
_____	_____	_____	_____
Address			
_____			

 e. Premium \$ \_\_\_\_\_  Lump Sum \_\_\_\_\_  1035 exchange  Planned Periodic Premium \_\_\_\_\_

**BACKGROUND/HEALTH QUESTIONS**

**YES NO**

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

Name	Co. Name	Amt. of Coverage/Benefit	Pol. No.
<input type="checkbox"/> Life	<input type="checkbox"/> Health	<input type="checkbox"/> Long-term Care	<input type="checkbox"/> Disability/Period _____
			<input type="checkbox"/> Annuity

Name	Co. Name	Amt. of Coverage/Benefit	Pol. No.
<input type="checkbox"/> Life	<input type="checkbox"/> Health	<input type="checkbox"/> Long-term Care	<input type="checkbox"/> Disability/Period _____
			<input type="checkbox"/> Annuity

Name	Co. Name	Amt. of Coverage/Benefit	Pol. No.
<input type="checkbox"/> Life	<input type="checkbox"/> Health	<input type="checkbox"/> Long-term Care	<input type="checkbox"/> Disability/Period _____
			<input type="checkbox"/> Annuity

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

Name	Co. Name	Type of Coverage	Amt. of Coverage/Benefit	Pol. No.
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Name	Co. Name	Type of Coverage	Amt. of Coverage/Benefit	Pol. No.
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Name	Co. Name	Type of Coverage	Amt. of Coverage/Benefit	Pol. No.
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13. Within the past 5 years, has any proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? If "Yes," provide details below .....

Name	Type	Date of Last Use	Frequency/Amount
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Name	Type	Date of Last Use	Frequency/Amount
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14. Has any proposed insured ever had an application for insurance modified, rated, declined, postponed, or withdrawn? .....  
If "Yes," provide details below.

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

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

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

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

Name	Date of Occurrence	County and State	Disposition
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Details

Name	Date of Occurrence	County and State	Disposition
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Details

**YES**  **NO**

17. Does any proposed insured intend to travel or reside outside of the United States within the next year? .....  
If "Yes,"

Name(s) _____	City/Country where traveling _____	Length of Stay _____	Times Per Year _____
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Purpose of Travel _____	Do you plan to visit non-urban areas _____	Trips outside of U.S. in prior two years _____	
-------------------------	--	--	--

Name(s) _____	City/Country where traveling _____	Length of Stay _____	Times Per Year _____
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Purpose of Travel _____	Do you plan to visit non-urban areas _____	Trips outside of U.S. in prior two years _____	
-------------------------	--	--	--

18. Is any proposed insured **NOT** a citizen of the United States? .....  
If "Yes,"

Name of proposed insured \_\_\_\_\_

Name of proposed insured \_\_\_\_\_

Date of entry into the U.S. \_\_\_\_\_

Date of entry into the U.S. \_\_\_\_\_

Name of country of citizenship \_\_\_\_\_

Name of country of citizenship \_\_\_\_\_

Have Permanent Resident Card?  Yes  No

Have Permanent Resident Card?  Yes  No

If "Yes," Provide A # \_\_\_\_\_

If "Yes," Provide A # \_\_\_\_\_

If No, does the proposed insured have a Visa?  Yes  No

If No, does the proposed insured have a Visa?  Yes  No

If "Yes," Type of Visa: \_\_\_\_\_ (provide copy)

If "Yes," Type of Visa: \_\_\_\_\_ (provide copy)

Intentions after expiration of Visa \_\_\_\_\_

Intentions after expiration of Visa \_\_\_\_\_

Does the proposed insured own a home in the U.S.?

Yes  No

Does the proposed insured own a home in the U.S.?

Yes  No

Are any family members U.S. Citizens or Permanent Residents?

Yes  No

Are any family members U.S. Citizens or Permanent Residents?

Yes  No

If "Yes," give details \_\_\_\_\_

If "Yes," give details \_\_\_\_\_

If no Permanent Resident Card and no Visa, please explain: \_\_\_\_\_

If no Permanent Resident Card and no Visa, please explain: \_\_\_\_\_

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

Name \_\_\_\_\_ Details \_\_\_\_\_

If "Yes," submit an Aviation Questionnaire.

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

Name \_\_\_\_\_ Details \_\_\_\_\_

If "Yes," submit an Avocation Questionnaire.

**AGENT USE ONLY**

**MEDICAL EXAMINATION WILL BE SCHEDULED FOR: Primary Proposed Insured** .....

**Additional Proposed Insured** .....

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

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

If "Yes," name(s) of proposed insured(s) \_\_\_\_\_

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

If "Yes," name(s) of proposed insured(s) \_\_\_\_\_

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

YES NO

**Questions 22 through 38 are only for persons proposed for insurance who are NOT expected to be subject to a Medical Examination. All applicants may, nevertheless, be subject to a Medical Examination at the Company's option.**

Please complete questions 22-38 for each person who did not check "Yes" above, and for each child who is not an additional proposed insured:

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

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

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

25. In the immediate family of any proposed insured, is there a history of high blood pressure, heart disease prior to age 60, kidney disease, stroke, diabetes prior to age 55, sickle cell anemia, cerebrovascular disorder, aneurysm, or cancer? .....    
 If "Yes," Name of Proposed Insured: \_\_\_\_\_  
 Relationship to Proposed Insured \_\_\_\_\_ Type/Details \_\_\_\_\_  
 Name of Proposed Insured: \_\_\_\_\_  
 Relationship to Proposed Insured \_\_\_\_\_ Type/Details \_\_\_\_\_

26. Does any proposed insured have a history of high blood pressure? .....    

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

YES NO

27. Does any proposed insured have diabetes? .....

If "Yes," Name \_\_\_\_\_

If "Yes," Name \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Describe treatment \_\_\_\_\_

Describe treatment \_\_\_\_\_

List any disability related to diabetes \_\_\_\_\_

List any disability related to diabetes \_\_\_\_\_

Last blood sugar or HA1C reading and date \_\_\_\_\_

Last blood sugar or HA1C reading and date \_\_\_\_\_

Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes?  Yes  No

Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes?  Yes  No

If "Yes," provide details \_\_\_\_\_

If "Yes," provide details \_\_\_\_\_

Name and address of physician treating diabetes \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name and address of physician treating diabetes \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

28. Within the past 5 years, has any proposed insured consumed alcoholic beverages? .....

If "Yes," Name \_\_\_\_\_ Average No. of drinks per week \_\_\_\_\_

Maximum No. of drinks per day \_\_\_\_\_ Type (Beer, Wine, Liquor) and Date of last use \_\_\_\_\_

Name \_\_\_\_\_ Average No. of drinks per week \_\_\_\_\_

Maximum No. of drinks per day \_\_\_\_\_ Type (Beer, Wine, Liquor) and Date of last use \_\_\_\_\_

29. Has any proposed insured ever received medical treatment or counseling from a physician for, or been advised by a physician to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has any proposed insured used such a non-prescribed drug or controlled substance, or any prescription medication other than as prescribed by a physician? .....

If "Yes," Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

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

Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

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

30. Within the past 10 years, has any proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for the Human Immunodeficiency Virus (HIV)? .....

If "Yes," Name \_\_\_\_\_ Details \_\_\_\_\_

Name and Address of Physician \_\_\_\_\_

If "Yes," Name \_\_\_\_\_ Details \_\_\_\_\_

Name and Address of Physician \_\_\_\_\_

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

If "Yes," Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

Details \_\_\_\_\_

Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

Details \_\_\_\_\_



38. Does any proposed insured have any symptoms or knowledge of any other condition that is **NOT** disclosed in previous questions? ..... YES  NO

Explain "Yes" answers to Questions 36-38.

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

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

**OWNER'S CERTIFICATION**

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

Under penalties of perjury, I certify that I am not subject to backup withholding because:

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

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

You must cross out item (b) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends in your tax return.

X \_\_\_\_\_  
Signature of Owner Date

**Consent to Insurance on Life of Minor Primary Proposed Insured**

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

X \_\_\_\_\_  
Signature of Biological/Adoptive Father or Mother or of Legal Guardian Date

X \_\_\_\_\_  
Signature of Biological/Adoptive Father or Mother or of Legal Guardian Date

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

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

X \_\_\_\_\_  
Signature of Biological/Adoptive Father or Mother Date

**AGENT'S CERTIFICATION**

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

\_\_\_\_\_ Date Signature of Licensed Agent

**ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZATION – NOTICE**

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

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

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

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

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

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

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

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

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

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

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

**PRIMARY PROPOSED INSURED** - If an investigative consumer report is prepared in connection with this application:

I elect to be interviewed.  I elect NOT to be interviewed.

**ADDITIONAL PROPOSED INSURED** - If an investigative consumer report is prepared in connection with this application:

I elect to be interviewed.  I elect NOT to be interviewed.

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

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

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

X \_\_\_\_\_ X \_\_\_\_\_  
SIGNATURE OF WITNESS (IF APPLICABLE) SIGNATURE OF LICENSED AGENT

**IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED**

**THE FOLLOWING INFORMATION AFFECTS YOUR LEGAL RIGHTS - READ CAREFULLY**

1. THE POLICY FOR WHICH YOU HAVE APPLIED INCLUDES A BINDING ARBITRATION AGREEMENT.
2. THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISAGREEMENT RELATED TO THIS POLICY MUST BE RESOLVED BY ARBITRATION AND NOT IN A COURT OF LAW.
3. THE RESULTS OF THE ARBITRATION ARE FINAL AND BINDING ON YOU AND THE INSURANCE COMPANY.
4. IN AN ARBITRATION, AN ARBITRATOR, WHO IS AN INDEPENDENT, NEUTRAL PARTY, GIVES A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES.
5. WHEN YOU ACCEPT THE INSURANCE POLICY, YOU AGREE TO RESOLVE ANY DISAGREEMENT RELATED TO THE POLICY BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT, INCLUDING A TRIAL BY JURY.
6. ARBITRATION TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY AND THE DECISION OF THE ARBITRATOR CANNOT BE REVIEWED IN COURT BY A JUDGE AND JURY.

**ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT**

I HAVE READ THIS STATEMENT. I UNDERSTAND THAT I AM VOLUNTARILY SURRENDERING MY RIGHT TO HAVE ANY DISAGREEMENT BETWEEN THE INSURANCE COMPANY AND MYSELF RESOLVED IN COURT. THIS MEANS I AM WAIVING MY RIGHT TO A TRIAL BY JURY.

I UNDERSTAND THAT, UPON RECEIPT OF THE POLICY, I SHOULD READ THE ARBITRATION AGREEMENT CONTAINED IN THE POLICY. FROM THE DATE OF ITS RECEIPT, I HAVE THE RIGHT TO REJECT THE POLICY WITHIN TWENTY (20) DAYS IF I DO NOT WANT TO ACCEPT THE REQUIREMENT FOR ARBITRATION OR FOR ANY OTHER REASON.

I UNDERSTAND THAT THIS SAME TYPE OF INSURANCE MAY BE AVAILABLE THROUGH AN INSURANCE COMPANY THAT DOES NOT REQUIRE THAT POLICY-RELATED DISAGREEMENTS BE RESOLVED BY BINDING ARBITRATION.

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

\_\_\_\_\_  
AGENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

**AGENT'S REPORT**

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

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

3. Owner's Telephone No. \_\_\_\_\_  
Email Address \_\_\_\_\_

4. Payor's Telephone No. \_\_\_\_\_  
Email Address \_\_\_\_\_

5. Beneficiary Name(s) \_\_\_\_\_  
Email Address(es) \_\_\_\_\_

6. Household Annual Earned Income \_\_\_\_\_

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

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

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

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

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

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

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

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

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

16. Agent's Daytime Phone Number \_\_\_\_\_  
Agent's Email Address \_\_\_\_\_

17.

**NON-PREMIUM FINANCING CERTIFICATION**

Will the insurance contemplated by this application be premium financed, other than by a split-dollar agreement?  Yes  No

If "Yes," provide explanation in the REMARKS section below.

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

Agent's Signature \_\_\_\_\_

Agent's Name (Print) \_\_\_\_\_ Date \_\_\_\_\_

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

**AMOUNT OF COLLECTION**

Name of Proposed Insured \_\_\_\_\_ Plan \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

Name of Proposed Insured \_\_\_\_\_ Plan \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

Name of Proposed Insured \_\_\_\_\_ Plan \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**REMARKS**

**AUTOMATIC BANK CHECK (ABC) AUTHORIZATION**

CO	POLICY NUMBER	NAME OF INSURED	CO	POLICY NUMBER	NAME OF INSURED

**New Issues: Please select one option.**

Draft Initial Premium       Collect Initial Premium \$ \_\_\_\_\_       Collect On Delivery of Policy (COD)

<input type="checkbox"/> Retail ABC Withdrawal Day _____ (1st thru 28th only) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	<input type="checkbox"/> Employer Sponsored ABC Withdrawal Day _____ (1st thru 28th only) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual
--	--

**BANK ACCOUNT INFORMATION**       **Checking Account**       **Savings Account**

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

Bank Account Number: \_\_\_\_\_

Bank Account Owner Name(s): \_\_\_\_\_ Email: \_\_\_\_\_

Bank Account Owner Full Address: Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**AGREEMENT:** As a convenience to me (us), I (we) request and authorize American General Life and Accident Insurance Company ("Company") to initiate debit entries, electronically, by paper means, or by any other commercially accepted method to my (our) checking/savings account maintained at the depository institution indicated for payment to the Company. I (we) additionally authorize the Company to debit for any full or partial balance due for the initial premium or for any reinstatement premium on the date of the Company's initial debiting of my account and thereafter as necessary. This authority is to remain in full force and effect until Company or Depository Institution has received **written notification of termination of the ABC Account, from me (or either of us), 30 days prior to the collection date**, or until the ABC account otherwise terminates.

Bank Account Owner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Joint Account:  
 Bank Account Owner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INDEMNIFICATION AGREEMENT**

To financial institution named on the reverse side:

In consideration of your compliance with, from time to time, the request and authorization of any account owner of your institution (individually, an "Account owner" and collectively, the "Account owners") to debit his or her account upon initiation by the American General Life and Accident Insurance (the "Company") and its affiliated companies; the Company does hereby agree:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or other written order, whether or not genuine, purporting to be executed by the Company and received by you in the regular course of business for the purpose of payment including any costs or expenses reasonably incurred in connection herewith.
2. In the event that any such check, draft or other written order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our cost and expense any action which might be brought by an account owner or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

*Debra Woodard*  
 Debra Woodard, Vice-President - Customer Services

**AGREEMENT:** As a convenience to me (us), I (we) request and authorize American General Life and Accident Insurance Company ("Company") to initiate debit entries, electronically, by paper means, or by any other commercially accepted method to my (our) checking/savings account maintained at the depository institution indicated for payment to the Company. I (we) additionally authorize the Company to debit for any full or partial balance due for the initial premium on the date of the Company's initial debiting of my account and thereafter as necessary. This authority is to remain in full force and effect until Company or Depository Institution has received **written notification of termination of the ABC account, from me (or either of us), 30 days prior to the collection date**, or until the ABC account otherwise terminates. It is agreed that:

1. Debit entries shall be initiated by and payable to the Company for premiums and/or policy loan repayments as directed by me (us). It will not be necessary for any officer or employee of the Company to sign such debit entries.
2. No liability shall be incurred by the Company or other issuing company of the policy by reason of the dishonor of such debit entries.
3. Any requirements for giving notice of premiums due shall be waived as long as this ABC plan is in effect; the bank account charge shall constitute a receipt, but no payment shall be deemed to have been made unless and until the Company receives actual payment in its Home Office. Use of the ABC plan shall in no way alter or amend the provisions of the policy(ies) as to premium payment. Request by me (us) that such charges be drawn on other than the premium due date does not alter the due date and the Company in no way waives or modifies such due date for the grace period provision in connection therewith.
4. If I (we) entered into this agreement to authorize the Company to withdraw money from a bank account to pay premiums that may become payable for a policy applied for by me (us), except as stated in the conditional receipt, I (we) understand that no insurance applied for will become effective unless the Company issues a policy from the application for this policy, the first premium is paid, and any other terms and conditions of the policy are met.
5. In the event I (we) later elect to rescind this authorization or if the Company determines that I (we) am no longer eligible for this mode of premium payment, I (we) recognize that the premiums thereafter payable shall be payable in the amount and in the manner as provided in the policy.
6. This plan shall continue in effect unless or until terminated by the Company, or by me (us), **by written notice 30 days prior to the collection date** to the other party. In addition, the Company may terminate the plan immediately if any charges are not paid upon presentation.

**Important Instructions:** (1) Fully complete ABC Authorization Agreement Form to open a new ABC account; (2) Sign and date Authorization Agreement Form; (3) Leave completed form attached to application and (4) Complete customer receipt, (above) detach receipt and give to customer.

**REFERRALS**

Name	Address	Phone (home/work)	Age
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

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ABC AGREEMENT - CUSTOMER RECEIPT

Bank Account Owner Name(s): \_\_\_\_\_ Date: \_\_\_\_\_

Bank Name: \_\_\_\_\_ Bank Account Number \_\_\_\_\_

**AGREEMENT:** As a convenience to me (us), I (we) request and authorize American General Life and Accident Insurance Company ("Company") to initiate debit entries, electronically, by paper means, or by any other commercially accepted method to my (our) checking/savings account maintained at the depository institution indicated for payment to the Company. I (we) additionally authorize the Company to debit for any full or partial balance due for the initial premium on the date of the Company's initial debiting of my account and thereafter as necessary. This authority is to remain in full force and effect until Company or Depository Institution has received written notification of termination of the ABC account, from me (or either of us), 30 days prior to the collection date, or until the ABC account otherwise terminates. It is agreed that:

1. Debit entries shall be initiated by and payable to the Company for premiums and/or policy loan repayments as directed by me (us). It will not be necessary for any officer or employee of the Company to sign such debit entries.
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3. Any requirements for giving notice of premiums due shall be waived as long as this ABC plan is in effect; the bank account charge shall constitute a receipt, but no payment shall be deemed to have been made unless and until the Company receives actual payment in its Home Office. Use of the ABC plan shall in no way alter or amend the provisions of the policy(ies) as to premium payment. Request by me (us) that such charges be drawn on other than the premium due date does not alter the due date and the Company in no way waives or modifies such due date for the grace period provision in connection therewith.
4. If I (we) entered into this agreement to authorize the Company to withdraw money from a bank account to pay premiums that may become payable for a policy applied for by me (us), except as stated in the conditional receipt, I (we) understand that no insurance applied for will become effective unless the Company issues a policy from the application for this policy, the first premium is paid, and any other terms and conditions of the policy are met.
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**MIB PRE-NOTICE**

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American General Life and Accident Insurance Company, or its reinsurer(s), may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

AGLA1000 MIB (1004)

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

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

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

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

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

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

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Date Local Office Agency No. Signature of Licensed Agent

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

AGLA1000-AL (0910) CR

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

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

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

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Date Local Office Agency No. Signature of Licensed Agent

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

AGLA1000-AL (0910) CR

**MIB PRE-NOTICE**

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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AGLA1000 MIB (1004)

AGLA1000-AL (0910)

**NOTICE OF INFORMATION PRACTICES**

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

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

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

AGLA1000 NIP (1004)

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**NOTICE TO HOLDER OF CONDITIONAL RECEIPT**

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:

- (a) decline to issue insurance; or
- (b) issue a policy other than as applied for and you do not accept it.

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

AGLA1000-AL (0910) CR

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**NOTICE TO HOLDER OF CONDITIONAL RECEIPT**

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:

- (a) decline to issue insurance; or
- (b) issue a policy other than as applied for and you do not accept it.

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

AGLA1000-AL (0910) CR

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

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AGLA1000 NIP (1004)

AGLA1000-AL (0910)