Tips for Submitting a Complete and Compliant Replacement

If the application being submitted includes existing coverage, the following tips will assist in completing the replacement form and application.

Part A Application

Existing Coverage Question

- Answer 'yes' or 'no' to the Existing Coverage question. If answer is 'yes':
  - Enter the Existing Policy Number, or write 'Unknown' in the space provided
  - Enter the Name of the Existing Carrier
  - Enter the Face Amount of the existing coverage

Replacement Question

- Answer 'yes' or 'no' to the Replacement question.
  - If the existing coverage is 'Pending', the Replacement question should be answered 'no', unless the pending policy is under a binding or conditional receipt or is within an unconditional receipt refund period, even if the pending policy will not be put in force.
  - If the replacement question is answered 'yes', then a Replacement Notice is required. **However, in states that require notice form AGLC0188, the form should be completed if the Existing Coverage question is answered 'yes', even if not replacing.**

Agent's Report

- Answer 'yes' or 'no' to the Existing Coverage question.
- Answer 'yes' or 'no' to the Replacement question
- Both of these questions on the Agent's Report should match what the applicant indicated on the Part A.
- Complete all fields, including license number, agent address, agent phone number, etc.

Replacement Notice

- Verify that you have 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 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. **The Replacement Notice 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 Replacement Notice; 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.

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

American General
Life Companies

Life Insurance Application Part A

☐ **American General Life Insurance Company, Houston, TX**
☐ **The United States Life Insurance Company in the City of New York, New York, NY**
☐ **American General Life Insurance Company of Delaware, Wilmington, DE**
Subsidiaries of American International Group, Inc.

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.

Personal Information

1. Primary Proposed Insured

Name ______ Social Security # ______
Sex ☐ M ☐ F Birthplace* *(state, country)* ______ Date of Birth ______ Current Age ____
Tobacco Use Have you ever used any form of tobacco or nicotine products? ☐ yes ☐ no If yes, date of last use ______
If yes, *type* and *quantity* of tobacco or nicotine products used ______
Driver's License ☐ yes ☐ no Number ______ License State ______
U.S. Citizen ☐ yes ☐ no If no, Date of Entry ______ Visa Type ______ Exp. Date ______
Address ______ City, State ______ ZIP ______
Home Phone ( ) ______ Work Phone ( ) ______ Email ______
Employer ______ Occupation ______ Length of Employment ______
Employer Address ______ City, State ______ ZIP ______
Duties ______
Personal Earned Income $ ______ Household Income $ ______ Net Worth $ ______
If Primary Proposed Insured is a child or is age 18 or over and not self-supporting, what amount of insurance is in force on any of the following: Spouse $______ Father $ ______ Mother $ ______ Siblings $ ______

2. Other Proposed Insured

Name ______ Social Security # ______
Sex ☐ M ☐ F Birthplace* *(state, country)* ______ Date of Birth ______ Current Age ____
Relationship to Primary Proposed Insured ______
Tobacco Use Have you ever used any form of tobacco or nicotine products? ☐ yes ☐ no If yes, date of last use ______
If yes, *type* and *quantity* of tobacco or nicotine products used ______
Driver's License ☐ yes ☐ no Number ______ License State ______
U.S. Citizen ☐ yes ☐ no If no, Date of Entry ______ Visa Type ______ Exp. Date ______
Address ______ City, State ______ ZIP ______
Home Phone ( ) ______ Work Phone ( ) ______ Email ______
Employer ______ Occupation ______ Length of Employment ______
Employer Address ______ City, State ______ ZIP ______
Duties ______
Personal Earned Income $ ______ Household Income $ ______ Net Worth $ ______

Ownership

3. A. Complete if the Primary Proposed Insured is not the Owner *(If contingent Owner is required, use Remarks section.)*

Name______ Social Security or Tax ID # ______ Date of Birth ______
Address ______ City, State ______ ZIP______
Home Phone ( ) ______ Relationship to Primary Proposed Insured ______
Email ______

B. Complete if Owner is a trust (*If trustee is premium payor, also complete section 14 D.)*

Exact Name of Trust ______ Trust Tax ID # ______
Address ______ City, State ______ ZIP______
Email ______
Current Trustee(s) ______ Date of Trust ______

**for identification purposes only*

Product Information

4. Product Name *(Complete appropriate supplemental application if applicable.)* ____________________

Amount Applied For: Base Coverage $ ____________ Supplemental Coverage *(If applicable)* $ ____________

Death Benefit Compliance Test Used *(If applicable):* ☐ Guideline Premium ☐ Cash Value Accumulation

Automatic Premium Loan *(If applicable):* ☐ Yes ☐ No Premium Class Quoted ____________________

Reason for Insurance ____________________

5. Dividend Options *(For participating policy only.)*

☐ Cash ☐ Premium Reduction ☐ Paid-up Additions ☐ Deposit Earning Interest ☐ Other *(Explain)* ____________

6. Premium Allocation *(For Indexed UL only if applicable.)*

Indicate how each premium received is to be allocated. **Total allocations must equal 100%. Use whole percentage only.**

Indexed Interest Account ________% Excess Interest Account ________% Total 100%

7. Death Benefit Options *(For UL & VUL only.)* ☐ Option 1 - Level ☐ Option 2 - Increasing ☐ Option 3 – Level Plus Return of Premium

8. Riders/Benefits

☐ Child Rider Amount $ ____________ **(Complete Child Rider Attachment)** or ☐ No current children

☐ Waiver of Premium ☐ Waiver of Monthly Deduction ☐ Waiver of Monthly Guarantee Premium

☐ Maturity Extension Rider – Accumulation Value ☐ Maturity Extension Rider – Death Benefit ☐ Terminal Illness Rider

☐ Accidental Death Benefit Amount $ ____________ ☐ Other Insured/Spouse Rider Amount $ ____________

☐ Disability Income Rider *(Complete the following if DI Rider is requested)*

Number of Units *(1 unit = $100):* ____________ Occupational Class *(Please check):* ☐ 1 ☐ 2

☐ Adjustable Return of Premium Rider – *(Provide % of Premium)* ____________

☐ Scheduled Increase Rider

☐ Other Riders/Benefits #1 ____________ Amount/Unit(s) ____________

☐ Other Riders/Benefits #2 ____________ Amount/Unit(s) ____________

Beneficiary

9. Primary

Name ____________ Relationship ____________ Share ______%

Name ____________ Relationship ____________ Share ______%

Name ____________ Relationship ____________ Share ______%

Name ____________ Relationship ____________ Share ______%

10. Contingent

Name ____________ Relationship ____________ Share ______%

Name ____________ Relationship ____________ Share ______%

Name ____________ Relationship ____________ Share ______%

11. Trust Information (if Beneficiary) Exact Name of Trust ____________________

Trust Tax ID # ____________ Current Trustee(s) ____________ Date of Trust ____________

12. Rider Beneficiaries *(Complete if other than Primary Proposed Insured.)*

Other Insured/Spouse Rider ____________ Relationship ____________

Child Rider ____________ Relationship ____________

Business Coverage

13. Business Insurance Details *(Complete only if applying for business coverage.)*

Does any Proposed Insured have an ownership interest in the business? ☐ yes ☐ no

If yes, what is the percentage of ownership for the: Primary Proposed Insured ______% Other Proposed Insured ______%

Net Profit of Business $ ____________ Fair Market Value of Business $ ____________

If buy-sell, stock redemption, or key person insurance, will all partners or key people be covered? ☐ yes ☐ no

Describe any special circumstances. ____________________

Premium

14. Premium Payment ☐ Modal $ __________ ☐ Single $__________ ☐ Additional Initial $ __________

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. Premium Payor *(Complete if other than Owner.)*

Name __________ Social Security or Tax ID # __________

Relationship to Primary Proposed Insured __________

Address __________ City, State __________ ZIP__________

Limited Temporary Life Insurance Eligibility

15. Health and Age Questions *(Regarding the Primary Proposed Insured and the Other Proposed Insured under a joint life or survivorship policy, if the correct answer to either question below is "yes" or any question is answered falsely or left blank, coverage is not available under the Limited Temporary Life Insurance Agreement ("LTLIA") and it is void, and any payment submitted will be refunded. Read the LTLIA for additional terms and conditions of coverage.)*

A. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? ☐ yes ☐ no

B. Is any Proposed Insured age 71 or above? ☐ yes ☐ no

Existing Coverage

16. Existing Coverage

A. Life and Annuity Coverage

Does any Proposed Insured have any existing or pending annuities or life insurance policies? ☐ **yes** ☐ **no**

(If yes, complete the following regarding such annuities or life insurance policies.)

Type: i = individual, **b**= business, **g**=group, **p**=pending life insurance or annuity

Name of Proposed Insured	Policy Number	Insurance Company	Type(s) *(see above)*	Year of Issue	Face Amount	Replace*	1035 Ex
						☐ yes ☐ no	☐ yes
						☐ yes ☐ no	☐ yes
						☐ yes ☐ no	☐ yes
						☐ yes ☐ no	☐ yes

***Replace** means that the insurance being applied for may replace, change or use any monetary value of any existing or pending life insurance policy or annuity. If replacement may be involved, complete and submit replacement-related forms. Please note: 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.

B. Disability Coverage ***(Complete only if Disability Income Rider coverage requested.)***

Does any Proposed Insured have any existing or pending Disability insurance policies? ☐ **yes** ☐ **no**

(If yes, complete the following regarding existing and pending disability insurance)

Insurance Company	Benefit Amount	Benefit Period	Elimination Period	Year Issued

Nonmedical Questions

17. Background Information *(Complete questions A through F. If yes answer applies to any Proposed Insured, provide details specified after each question.)*

A. Does any Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? ☐ yes ☐ no

(If yes, list country, date, length of stay and purpose.) ____________________

____

____

B. In the past five years, has any Proposed Insured participated in, or does he or she intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; extreme sports or other hazardous activities? ☐ yes ☐ no

(If yes, circle or list the applicable activities and complete the Aviation and/or Avocation Questionnaire.) ____________________

____

____

C. Has any Proposed Insured:

1) During the past 90 days submitted an application for life insurance to any company or begun the process of filling out an application? ☐ yes ☐ no

(If yes, list company name, amount applied for, purpose of insurance and if application will be placed.) ____________________

____

____

2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal? ☐ yes ☐ no

(If yes, list date and reason.) ____________________

____

____

D. Has any Proposed Insured ever filed for bankruptcy? ☐ yes ☐ no

(If yes, list chapter filed, date, reason and discharge date.) ____________________

____

____

E. In the past five years, has any Proposed Insured been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? ☐ yes ☐ no

(If yes, list date, state, license no. and specific violation.) ____________________

____

____

F. Has any Proposed Insured ever been convicted of or pled guilty or no contest to a criminal offense or currently have any felony or misdemeanor charge pending? ☐ yes ☐ no

(If yes, list date, state and charge.) ____________________

____

____

Remarks

18. Details and Explanations ____________________

____

____

____

____

____

____

The above listed life insurance company ("Company") as selected on page one of this application 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.

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured and Owner signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. 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, 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) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (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 answers to any questions 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 begin 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.

Limited Temporary Life Insurance Agreement ("LTLIA") – 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 following four conditions are met: (1) the full first modal premium is submitted with this application and paid; and (2) only "no" answers have been truthfully given to the Health and Age Questions in section 15; and (3) Part A and Part B of the application must be completed, signed and dated; and (4) all medical exam requirements must be satisfied. I understand and agree that such insurance is not available with 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 or have been read the Notices to the Proposed Insured(s).

I give my consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an affiliated service company), and 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 for me, my spouse or my minor children. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine: (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: 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 AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. ☐ Check if you wish to be interviewed.

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

Proposed Insured(s)/Owner Signature

Signed at (city, state) ______________________ On (date) ______________

Primary Proposed Insured **X** ______________________________
(If under age 15, signature of parent or guardian)

Other Proposed Insured **X** ______________________________
(If under age 15, signature of parent or guardian)

Owner *(If other than Primary Proposed Insured)* **X** ______________________________

Agent(s) Signature(s)

I certify that the information supplied by the Primary Proposed Insured(s)/Owner has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* ______________________ Writing Agent # ______________

Writing Agent Signature **X** ______________________ Countersigned ______________________
(Licensed resident agent if state required)

Agent's Report

1. Statements

A. Number of years you have known Primary Proposed Insured: ____________

Other Proposed Insured: ____________

B. Does any Proposed Insured have any existing or pending annuities or life insurance policies? ☐ yes ☐ no

If yes, do you have any information that indicates that any Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity with any company in connection with the purchase of insurance? ☐ yes ☐ no

(If yes, please provide details in the Remarks section below and attach all replacement-related forms. 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.)

C. Are you aware of any other information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability? *(If yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.)* ☐ yes ☐ no

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

2. Remarks, Details and Explanations *(Please include information on any collateral assignment, etc.)*

____

____

____

____

____

3. Commission, Agent/Agency Information *(Please list servicing agent first.)*

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
			%
			%
			%
			%

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

Writing Agent Signature **X** ____________

State License # ____________ Phone # ____________

Email ____________ Fax # ____________

For Home Office use

Processing Center ____________ Contact Person ____________ Phone # ____________

Servicing Agent (if other than writing agent) send policy/delivery requirements to ____________

____

American General
Life Companies

HIPAA Authorization - New Business

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

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

I hereby authorize all of the people and organizations listed below American General Life Insurance Company of Delaware, American General Life Insurance Company, American International Life Assurance Company of New York, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service company), (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

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

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

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

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

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

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

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

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

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

____ ____________________
Signature of Proposed Insured or
Proposed Insured's Personal Representative
Date

____
Description of Authority of Personal Representative
(if applicable)

BANK DRAFT AUTHORIZATION

☐ **American General Life Insurance Company, Houston, TX**

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

☐ **American General Life Insurance Company of Delaware, Wilmington, DE**

The company checked above ("Company") will withdraw the premiums from the specified account. "You", "your", "I", and "me" refer to the bank account Owner whose name appears below.

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

Automatic Bank Draft Agreement

I hereby authorize and request the Company 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 insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason or dishonor of any debit.

I 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 nonforfeiture provision. I acknowledge 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.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the nonterminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason.

This 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.

Financial Institution Name ____________________

Financial Institution Address ____________________ City, State ____________________ ZIP __________

Routing Number |: ☐☐☐☐☐☐☐☐☐ :|

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ||•

Type of Account: ☐ Checking ☐ Savings Credit Union: ☐ yes ☐ no

Name of Primary Proposed Insured ____________________ Premium Amount $ __________

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

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

Print Bank Account Owner(s) Name ____________________

Signature(s) of Bank Account Owner(s) **X** ____________________

Please attach voided check or deposit slip.

Detach this page and leave it 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

American General Life Insurance Company of Delaware, Wilmington, DE

You have applied for life insurance with one of the insurance companies identified above. "Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies LLC (AGLC), (a company providing services to affiliated life insurance companies that are members of American International Group, Inc.).

FAIR CREDIT REPORTING ACT

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

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

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

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

MEDICAL INFORMATION BUREAU

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

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

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

INSURANCE INFORMATION PRACTICES

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

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

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

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

TELEPHONE INTERVIEW INFORMATION

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

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

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

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

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

This form must be completed, signed and ***left with the applicant.***

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

☐ American General Life Insurance Company of Delaware,Wilmington, DE

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 had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed?	☐	☐
b. Is any Proposed Insured age 71 or above?	☐	☐

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.

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 Automatic Bank Draft Agreement; (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
- $500,000 plus the amount of any premium paid for coverage in excess of $500,000; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

4. Complete and sign this section:

Any misrepresentation contained in this Agreement or the Receipt 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 or the Receipt.

I, the Owner, have received and read this Agreement and the Receipt or they were read to me and agree to be bound by the terms and conditions stated herein.

Signature of Owner ______________________________ Date ______________

Signature of Primary Proposed Insured ______________________________ Date ______________

Signature of Other Proposed Insured *(if applicable)* ______________________ Date ______________

Writing Agent Name *(please print)* ______________________________ Writing Agent # __________

This form to be completed, detached and ***submitted with the signed application.***

Limited Temporary Life Insurance Agreement Receipt

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
- ☐ American General Life Insurance Company of Delaware, Wilmington, DE

In this Receipt, "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. The "Agreement" refers to the Limited Temporary Life Insurance Agreement.

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 ______________________________

3. Answer the following questions:

	Yes	No
a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed?	☐	☐
b. Is any Proposed Insured age 71 or above?	☐	☐

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 the 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 the Agreement.

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 the Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under the Agreement have been met.

The total death benefit amount pursuant to the 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
- $500,000 plus the amount of any premium paid for coverage in excess of $500,000.

If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

4. Complete and sign this section:

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

I, the Owner, have received and read the Agreement and this Receipt or they were read to me and agree to be bound by the terms and conditions stated therein.

Signature of Owner ______________________________ Date ______________

Signature of Primary Proposed Insured ______________________________ Date ______________

Signature of Other Proposed Insured *(if applicable)* ______________________________ Date ______________

Writing Agent Name *(please print)* ______________________________ Writing Agent # __________

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, DC, LA, MA, MN, MS, NC, OH, OK, and TX.

- If the applicant is requesting the Terminal Illness Rider on any product that has this rider available, the attached form (AGLC102084 or AGLC101954-MA) must be completed and submitted with the application packet.
- Directions for completing the Part A:
  - If the Common App (AGLC100565) was completed, place a checkmark in the Terminal Illness Rider checkbox in Section 8.
  - If the Term App (AGLC100240) was completed, add the Terminal Illness Rider as an Other Riders / Benefits in Section 3 and place N/A in the Amount/Unit(s) line.

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

Please use the following information for the following states:

CT, IN, KS, MI, OR, VA and WA.

For AG Select-A-Term℠** or Ultra Series applications, the Terminal Illness Rider is not available due to state regulations.

- Do not complete this form.
- Do not request the Terminal Illness Rider on the Part A.

**Note: AG ROP Select-A-Term℠ is eligible to receive the Terminal Illness Rider.

For products other than AG Select-A-Term℠ or Ultra Series, the Terminal Illness Rider is available on products that have been filed with this rider.

- Complete the attached form AGLC102084.
- Complete the additional rider information on the Part A:
  - If the Common App (AGLC100565) was completed, place a checkmark in the Terminal Illness Rider checkbox in Section 8.
  - If the Term App (AGLC100240) was completed, add the Terminal Illness Rider as an Other Riders / Benefits in Section 3 and place N/A in the Amount/Unit(s) line.

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

American General
Life Companies

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

American General Life Insurance Company
A subsidiary of American International Group, Inc.

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

Limitations of the Accelerated Benefit:

You may use the money you receive from the Terminal Illness Accelerated Benefit Rider for any purpose. Unlike conventional life insurance proceeds, 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.

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. We will defer premiums on the policy and any attached riders;
2. A lien against future policy benefits will be established;
3. Any unpaid policy loan will be added to the lien;
4. The amount of the lien and any policy loan will be deducted from the Death Benefit;
5. Interest will accrue daily on paid out benefits and any deferred premiums.

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 12 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 death benefit proceeds payable under the base policy, but not to exceed $250,000.

D. Premium for Accelerated Benefit:

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

E. Administrative Expense Charge:

On the date the accelerated benefit is paid under this rider, an administrative fee not to exceed $250.00 will be established as a lien against future policy benefits.

______________________________ Signature of Applicant

______________________________ Signature of Agent

______________________________ Date

______________________________ Date

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

American General
Life Companies

HIV Testing and Consent
Texas Version

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

Subsidiaries of American International Group, Inc.

In this form, the "Company" refers to the insurance company whose name is checked above.

The insurance company checked above is **solely** 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.

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.

______________________________ ______________________________
Name of Proposed Insured (Please Print) Signature of Proposed Insured or Parent/Guardian

______________________________ ______________________________
Address Date

American General
Life Companies

Summary of Premium Provisions

American General Life Insurance Company
A subsidiary of American International Group, Inc.
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.

____
Signature of Proposed Insured

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