American General
Life Companies

Application for Accident and Health Insurance

American General Life Insurance Company
A subsidiary of American International Group, Inc.
2727-A Allen Parkway • Houston, TX 77019

"Proposed Insured" refers to primary, spouse, and children proposed for coverage in this application.

1. Primary Proposed Insured

Last First Middle

2. Address

Street

City State Zip Code

3. Social Security No.

4. Birth Date and Place
Month | Day | Year | State | Country

5. Age

6. Sex ❑ M ❑ F

7. U.S. Citizen ❑ Yes ❑ No
If no, date of entry _____ visa type _____

8. Spouse (if coverage applied for) Sex ❑ M ❑ F

Name _____
Last First Middle

Month | Day | Year | State | Country

Birth Date and Place Social Security No. Age

9. Primary Proposed Insured Height _____ Weight _____

10. Spouse Height _____ Weight _____

11. Beneficiary

Name _____
Last First Middle

Social Security No. Date of Birth Relationship

12. Primary Proposed Insured Driver's License
#_____ State of Issue _____

13. List Dependent(s) Information:

Full Name	Age	Relationship	Birth Date Mo. Day Yr.	Sex M	Sex F
a.				❑	❑
b.				❑	❑
c.				❑	❑
d.				❑	❑
e.				❑	❑

Insurance Plan

❑ **Accident**

Coverage Level
- ❑ Primary Proposed Insured
- ❑ Primary Proposed Insured/Spouse
- ❑ Family
- ❑ Primary Proposed Insured/Children

Deductible Amount: $ _____

Benefit Payable per Calender Year, per Insured: $ _____

❑ **Critical Illness Benefit Rider**

Coverage Level
- ❑ Primary Proposed Insured
- ❑ Primary Proposed Insured/Spouse
- ❑ Family
- ❑ Primary Proposed Insured/Children

Benefit Payable per Lifetime, per Insured:

Primary Proposed Insured $ _____

Spouse $ _____

Children $ _____

Questions 14-17 are only applicable if applying for the Critical Illness Benefit Rider.

14. Additional Information – In the past 1 year, had any Proposed Insured used tobacco (cigarette, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? ❑Yes ❑No

For a "Yes" answer, please indicate Primary Proposed Insured and/or Spouse. ❑Primary Proposed Insured ❑Spouse

Health Questions	Yes	No
15. Has any Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), for AIDS Related Complex (ARC), or for any disorder of the immune system, or tested positive for the Human Immunodeficiency Virus (HIV)?	❑	❑
16. In the last 5 years, has any Proposed Insured been diagnosed or received medical advice for cancer, leukemia, melanoma, malignant tumor, Hodgkin's disease or non-Hodgkin's lymphoma?	❑	❑
17. In the last 5 years, has any Proposed Insured been diagnosed as having or been treated for or consulted a licensed health care provider for:		
a. Stroke or transient ischemic attack (TIA)?	❑	❑
b. Diabetes?	❑	❑
c. Disease or disorder of the heart or blood vessels, heart attack or uncontrolled high blood pressure?	❑	❑
d. Kidney failure or abnormal kidney function?	❑	❑
e. An organ transplant or been advised of the need of an organ transplant?	❑	❑

Health History—Details For Any "Yes" Answers

Question #	Name of Proposed Insured	Relationship			Description
		Primary Proposed Insured	Spouse	Child	

All Coverage—Existing or Pending Insurance Question

Does any Proposed Insured have any existing or pending accident or sickness insurance?
(If yes, complete section following)

Name of Proposed Insured	Company Name	Type*	Face Amount	Replace** Yes	Replace** No
				❑	❑
				❑	❑
				❑	❑

* Type A = accident, CI = critical illness, or O = other

** Replace means that the insurance policy being applied for replaces any accident and sickness policy pending or presently in force including health, accident, critical illness, disability or cancer insurance. If replacement may be involved, complete and submit any state-required replacement forms.

Modal Premiums

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

Method: ❑Direct Billing ❑Bank Draft (Complete Bank Draft Authorization.) ❑List Bill: Number _____

❑Credit Card – Initial Premium Only (Complete Credit Card Authorization.)

Accident	Critical Illness Benefit Rider	Total Modal Premium
$_____	$_____	$_____

AGREEMENT – AUTHORIZATION – ACKNOWLEDGEMENT – UNDERSTANDING

between Proposed Insured ("You or Your") and the Company and its affiliates ("We" or "Us")

Agreement.

Your insurance will not begin until: (a) We have issued Your policy and (b) received Your first premium in full. You must pay your first premium in full within 45 days of the date Your policy is issued. Even if You pay Your premium in advance, there will be no coverage until the day Your policy is issued. If Your policy is not issued for any reason, We will (a) refund Your premium, and (b) have no liability regarding this application.

The policy You are applying for is NOT major medical insurance. It is a limited benefit policy. This means that it pays benefits only as defined in the policy. Benefits payable are subject to the conditions, limits, reductions and exclusions in the policy.

All statements and answers are complete and true to the best of Your knowledge and belief. No agent can: (a) waive any answer, (b) modify this application, (c) bind Us or (d) make any promise or representation not contained in this application.

Authorization.

By signing the application, You authorize Us to release the information obtained in the application in these circumstances only: (a) to reinsurers or other persons or entities performing business or legal services in connection with this application or claims, (b) as may be lawfully required, or (c) as You may further authorize.

A photocopy is as valid as an original. This Authorization will be valid for 24 months of the date signed below.

You or Your representative may request a copy. You also may revoke this Authorization at any time by written notification to Us at our Home Office.

Acknowledgement.

By signing this application, you acknowledge receipt of the Outline of Coverage, Notice to the Primary Proposed Insured and the HIPAA Privacy Notice. If you are completing this application using voice signature, you acknowledge that you already have a copy of the Outline of Coverage and the HIPAA Privacy Notice, and that Notices to the Primary Proposed Insured have either been read to you or provided to you.

Understanding.

If You are receiving Medicaid payments, benefits under the policy may reduce those payments or any Medicaid benefits otherwise payable.

Anyone who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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; (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).

Signed at _____ _____ _____

City State Date

X _____ X _____

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

Information Sharing (Optional)

By signing below, You further authorize Us to use and/or share the demographic information in this application to provide You with information about other products and/or service offered by Us.

X _____

Signature of Primary Proposed Insured

Agent Section.

I certify that I have asked each question and that the answers have been truly and accurately recorded as given to me. I have recorded any unfavorable information of which I have knowledge concerning any Proposed Insured. I also have provided the required Outlines of Coverage and the HIPAA Privacy Notice.

X _____ Sofia Baghaeimehr

Signature of Licensed Agent Printed Name of Agent

_____

Agent Number