# American General
Life Companies

## In-Force Change Application
## California Version

☐ **American General Life Insurance Company, Houston, TX**
☐ **The United States Life Insurance Company in the City of New York, New York, NY** (Non-NY Residents)
☐ **American General Life Insurance Company of Delaware, Wilmington, DE**

P.O. Box 4373 • Houston, TX 77210-4373 • Fax #: 713-831-3028

Some transactions may not be available for all policies for every company listed above. Contact your service center or agent for further details. In this application, "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 it may issue. No other company shown is responsible for such obligations or payments.

**Use permanent ink when completing this form. Be sure to answer all questions that pertain to your request. Provide details for any questions answered "Yes". Personally sign and date. If a separate page is needed to complete the answers, attach to this form and sign and date the separate page(s). Carefully read the Notices to the Proposed Insured(s) and keep with your policy.**

**Current Policy Number** _____ **Insured Name** _____

***Instructions: For these changes, please complete the entire application, sign and date page 5.***

**Requested Change:**

☐ Application for Reduction of Premium Rate/Reversion
☐ Increase Specified Amount:
Base Coverage: _____ Supplemental Coverage (if applicable)_____
☐ Addition or Increase of Rider &/or Benefit
- ☐ Waiver of Premium
- ☐ Waiver of Monthly Deduction
- ☐ Waiver of Monthly Guarantee Premium
- ☐ Payor Death
- ☐ Payor Disability
- ☐ Accidental Death Benefit: Amount _____
- ☐ Other Insured Rider: Amount _____
- ☐ Guaranteed Insurability Option Rider
- ☐ Child Rider: Amount _____
*(Complete all info for the primary insured & each child)*
- ☐ Spouse Rider: Amount _____ Plan: _____
*(Complete all info for the primary insured & spouse)*
- ☐ Term Rider: Amount _____ Plan: _____
Insured _____
- ☐ Other Rider: Amount _____ Explain type: _____

☐ Smoker/Tobacco/Nicotine Change: _____

***Instructions: For the changes listed below, complete Section I, sign and date page 5. If a face increase or benefit/rider addition is requested, complete the entire application, sign and date page 5.***

☐ Exercise Guaranteed Insurability Option (GIO)
GIO Amount: _____
Option Date: _____
Dividend Option: _____

Benefits: If the insured is totally disabled, the insured is not eligible for Waiver of Premium.
Is insured totally disabled? ☐ Yes ☐ No
☐ Waiver of Premium/Monthly Deduction
☐ Accidental Death Benefit
☐ Guaranteed Insurability Option
☐ Other_____

Automatic Premium Loan desired (if available)
☐ Yes ☐ No

***Note: Underwriting class changes are not available on a GIO transaction.***

☐ Term Conversion
CONVERSION AMOUNT
Base Coverage: _____
Supplemental Coverage: _____
Effective Date: _____
New Plan: _____
Dividend Option: _____*(if applicable)*
Benefits: If the insured is totally disabled, the insured is not eligible for Waiver of Premium.
Is insured totally disabled? ☐ Yes ☐ No
☐ Waiver of Premium/Monthly Deduction
☐ Accidental Death Benefit
☐ Guaranteed Insurability Option
☐ Other _____
Nonforfeiture Process: ___ETI or ___RPU
Automatic Premium Loan (if available) ☐ Yes ☐ No
Death Benefit Option: ☐ Level ☐ Increasing
☐ Level Plus Return of Premium
After the conversion, will there be any remaining coverage on the existing policy? ☐ Yes ☐ No
Amount remaining after conversion: _____

***New Policy #*** _____ ***(Office use only)***

**SECTION I – GENERAL INFORMATION:**

**A. PRIMARY INSURED**

First Name _____ MI ____ Last Name_____ Social Security # _____

Sex ☐ M ☐ F Birthplace (state, country) _____ Date of Birth _____

U.S. Citizen or Permanent Resident (Green Card holder) ☐ yes ☐ no

If no, Country of Citizenship _____ Date of Entry _____ Visa Type _____ (Copy of Visa Required)

☐ **CHECK HERE IF NEW ADDRESS**

Address _____ City, State _____ Zip _____

Home Phone_____ Alternate Phone_____ Email _____

Employer _____ Occupation _____

Personal Earned Income $ _____ Net Worth $ _____

Personal Earned Income means salary, wages, commissions, fees, or other earned income received during the last 12 months, reduced by regular business expenses, but before all other deductions.

**B. OTHER INSURED** *Complete if spouse or additional insured covered under the policy*

First Name _____ MI ____ Last Name_____ Social Security # _____

Sex ☐ M ☐ F Birthplace (state, country) _____ Date of Birth _____

U.S. Citizen or Permanent Resident (Green Card holder) ☐ yes ☐ no

If no, Country of Citizenship _____ Date of Entry _____ Visa Type _____ (Copy of Visa Required)

Address _____ City, State _____ Zip _____

Home Phone_____ Alternate Phone_____ Email _____

Employer _____ Occupation _____

Personal Earned Income $ _____ Net Worth $ _____

Personal Earned Income means salary, wages, commissions, fees, or other earned income received during the last 12 months, reduced by regular business expenses, but before all other deductions.

**C. CHILD INFORMATION** *Complete information for all children covered by child rider*

| Child Name | Sex | Date of Birth |
|---|---|---|
| _____ | ☐ M ☐ F | _____ |
| _____ | ☐ M ☐ F | _____ |
| _____ | ☐ M ☐ F | _____ |

**D. OWNER INFORMATION** *Complete if the primary insured is not the owner*

First Name _____ MI ____ Last Name_____ Tax ID #_____

☐ **CHECK HERE IF NEW ADDRESS**

Address _____ City, State _____ Zip _____

Home Phone_____ Alternate Phone_____ Email _____

If owner is a trust please designate information for the Name, Tax ID, Current Trustee and Date of Trust in the Special Remarks section.

**E. PREMIUM PAYMENT ENCLOSED**

☐ yes ☐ no Amount $ _____ Check # _____

**SECTION II:**

**A. BACKGROUND INFORMATION – For all covered persons**

**Complete questions 1 through 12 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details. You may be asked to complete and submit an additional form.**

**1.** Tobacco Use: Have you ever used any form of tobacco or nicotine products? ☐ yes ☐ no

If yes, *type* and *quantity* _____ Are you a current user? ☐ yes ☐ no

If not a current user, date of last use _____

**2.** Have you ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? ☐ yes ☐ no

**3.** Have you ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? ☐ yes ☐ no

**4.** Driver's License State: _____ Number: _____

In the past five years, have you been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs? ☐ yes ☐ no

**5.** In the past five years, have you participated in, or do you 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

**6.** Do you intend to travel or reside outside of the United States or Canada within the next two years? ☐ yes ☐ no

**7.** Have you ever requested or received a pension, benefits, or payments because of an injury, sickness, or disability? ☐ yes ☐ no

**8.** Have you ever filed for bankruptcy? ☐ yes ☐ no

**9.** Have you 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

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

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

**12.** Is the Owner, any Proposed Insured, or any person or entity, being paid (cash, services, etc) as an incentive to enter into this transaction? ☐ yes ☐ no

**Details:**

_____

_____

_____

**B. MEDICAL INFORMATION**

**1.** **Primary Insured:** Height ____ft ____in Weight ____ lbs Change of weight in last year? ☐ None Gain: ____ lbs Loss: ____ lbs

**Other Insured:** Height ____ft ____in Weight ____ lbs Change of weight in last year? ☐ None Gain: ____ lbs Loss: ____ lbs

**Child 1:** Height ____ft ____in Weight ____ lbs Change of weight in last year? ☐ None Gain: ____ lbs Loss: ____ lbs

**Child 2:** Height ____ft ____in Weight ____ lbs Change of weight in last year? ☐ None Gain: ____ lbs Loss: ____ lbs

**2.** Name and address of personal physician

**Primary Insured:** _____

**Other Insured:** _____

**Child 1:** _____

**Child 2:** _____

**3.** Date, reason, findings and treatment at last visit

**Primary Insured:** _____

**Other Insured:** _____

**Child 1:** _____

**Child 2:** _____

**B. MEDICAL INFORMATION (continued)**

**Complete questions 4 through 8 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details such as date of first diagnosis, name and address of doctor, tests performed, test results, medication(s) or recommended treatment.**

**4. Have you ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:**

**a.** heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? ☐ yes ☐ no

**b.** a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☐ no

**c.** cancer, tumors, masses, cysts or other such abnormalities? ☐ yes ☐ no

**d.** diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system? (excluding HIV tests) ☐ yes ☐ no

**e.** colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? ☐ yes ☐ no

**f.** a disorder of the kidneys, bladder, prostate or reproductive organs or protein in the urine? ☐ yes ☐ no

**g.** asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? ☐ yes ☐ no

**h.** seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including anxiety, depression or other psychiatric conditions? ☐ yes ☐ no

**i.** arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? ☐ yes ☐ no

**Details:** _____

_____

_____

**5.** Are you currently taking any medication, treatment or therapy or under medical observation? ☐ yes ☐ no

**Details:** _____

_____

**6.** Have you ever been diagnosed as having or been treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☐ no

**Details:** _____

_____

**7.** Other than previously stated, in the past 10 years have you been advised to have any diagnostic test (excluding HIV tests), hospitalization, or treatment that was NOT completed? ☐ yes ☐ no

**Details:** _____

_____

**8.** Do you have any symptoms or knowledge of any other condition that is NOT disclosed above? ☐ yes ☐ no

**Details:** _____

_____

**C. EXISTING COVERAGE**

**1. Does any Proposed Insured have any existing life insurance policies?** ☐ **yes** ☐ **no**

**2. If question 1 is answered "yes", please provide the following information:**

| Name of Proposed Insured | Type (see below) | Year of Issue | Face Amount | Insurance Company | Contract or Policy # |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Type:** **i**= individual, **b**= business, **g**= group

**D. SPECIAL REMARKS: Use this space to provide any additional comments or remarks not given in detail above**

_____

_____

_____

_____

## AUTHORIZATION AND SIGNATURES

**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 application, "Company" refers to the insurance company which was selected on page one.

**Authorization to Obtain and Disclose Information and Declaration**

I give my consent to all of the entities listed below to give to the Company, its legal representative, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations, treatments or surgeries; hospital confinements for any physical and 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 or changes to 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 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 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.

I have read the above statements 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 shall be the basis for: (1) any policy issued; or (2) changes to the existing policy as requested on this application. I understand that any misrepresentation contained in this application and related forms and relied on by the Company may be used to reduce or deny a claim or void the policy, if it is within its contestable period and if such misrepresentation materially affects the acceptance of the risk. I understand and agree that no insurance will be in effect under this application, or under any new policy issued by the Company, unless or until: the policy has been delivered and accepted; the first full modal premium for the issued policy has been paid; and to the best of my knowledge and belief there has been no change in the health of any proposed insured that would change the answers to any questions in the application.

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).

Any person 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.

**If this is a full term conversion, please note:**

**I HEREBY ABSOLUTELY ASSIGN AND TRANSFER TO THE COMPANY IDENTIFIED IN THIS APPLICATION ALL OF MY RIGHTS, TITLE AND INTEREST OF EVERY KIND IN AND TO THE CURRENT POLICY INCLUDING, BUT NOT LIMITED TO THE RIGHT TO SURRENDER, ASSIGN, TRANSFER OR CHANGE THE BENEFICIARY.**

**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).

**Signed at** (City and State) | **Date**

**Signature of Primary Insured** (if under age 15, signature of parent or guardian)

**Signature of Other Insured** (if under age 15, signature of parent or guardian)

**Signature of Owner** (if other than insured) | **Signature of Officer and Title** (if corporate owned)

**Signature of Trustee** (if owned by a trust) | **Agent Signature** | **Date**

Sofia Baghaeimehr

**Agent Name** (Printed) | **State License #**

8189330000

**Percentage of Commissions** | **Agent Telephone #**