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
California Version

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

1. Primary Proposed Insured

First Name _____ MI __ Last Name _____ 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 *Type* and *quantity* used _____

If yes, are you a current user? ☐yes ☐no If no, date of last use _____

Driver's License ☐yes ☐no License State _____ Number _____

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 _____ Length of Employment _____

Employer Address _____ City, State _____ ZIP _____

Duties _____

Personal Earned Income $ _____ Household 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.

If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force on any of the following: Spouse $_____ Father $ _____ Mother $ _____ Siblings $ _____

2. Other Proposed Insured

First Name _____ MI __ Last 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 *Type* and *quantity* used _____

If yes, are you a current user? ☐yes ☐no If no, date of last use _____

Driver's License ☐yes ☐no License State _____ Number _____

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 _____ Length of Employment _____

Employer Address _____ City, State _____ ZIP _____

Duties _____

Personal Earned Income $ _____ Household 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.

**for identification purposes only*

3. Owner

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

First Name _____ MI ____ Last Name _____ Sex ☐ M ☐ F

Social Security or Tax ID # _____ Date of Birth _____

U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship _____ Date of Entry _____ Visa Type _____ Exp. Date _____

Address _____ City, State _____ ZIP _____

Home Phone ( ) _____ Relationship to Primary Proposed Insured _____

Email _____

B. Complete if Owner is a trust (*If trustee is a premium payor, also complete section 13 D)*

Exact Name of Trust _____ Trust Tax ID # _____

Address _____ City, State _____ ZIP _____

Email _____

Current Trustee(s) _____ Date of Trust _____

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. Premium Allocation *(For Index UL only) (Complete line A, line B or line C based on the selected product)*

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

A. 1-Year Index Interest Account _____% 5-Year Index Interest Account _____% Declared Interest Account _____%

B. 1-Year Index Cap Account _____% Annual Participation Rate Account _____% Declared Interest Account _____%

C. 1-Year Index Cap Account _____% 5-Year Index Interest Account _____% Declared Interest Account _____%

Other: _____

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

7. 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 $ _____

☐ Select Income Rider *(Complete the following if SI Rider selected)* Benefit Duration _____ Monthly Benefit Amt $ _____

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

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

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

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

8. Primary Beneficiary

Name _____ Relationship _____ Share _____% DOB _____ SSN _____

Name _____ Relationship _____ Share _____% DOB _____ SSN _____

Name _____ Relationship _____ Share _____% DOB _____ SSN _____

Name _____ Relationship _____ Share _____% DOB _____ SSN _____

9. Contingent Beneficiary

Name _____ Relationship _____ Share _____% DOB _____ SSN _____

Name _____ Relationship _____ Share _____% DOB _____ SSN _____

10. Trust Information (if Beneficiary) Exact Name of Trust _____

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

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

Other Insured/Spouse Rider _____ Relationship _____

12. 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

If no, provide the reason why all partners are not covered _____

Describe any special circumstances _____

_____

13. 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) (Not available for VUL products)*

☐ Other *(Please explain)*_____

C. Amount submitted with application $ _____

D. Premium Payor *(Complete if other than Owner or if Owner is Trustee)*

First Name _____ MI ____ Last Name _____Sex ☐ M ☐ F

Social Security or Tax ID # _____ Date of Birth _____

Relationship to Primary Proposed Insured _____

U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship _____ Date of Entry _____ Visa Type _____ Exp. Date _____

Address _____ City, State _____ ZIP_____

14. Existing Coverage and Replacements

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

B. If question 14A 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 #	Is Coverage being Replaced?**	1035 Exchange
						☐ yes ☐ no	☐ yes
						☐ yes ☐ no	☐ yes
						☐ yes ☐ no	☐ yes
						☐ yes ☐ no	☐ yes

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

*If 14A is answered "yes", certain states require completion of replacement-related forms even when existing or pending life insurance or annuities are not being replaced by the life insurance policy being applied for.

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

C. 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

15. Background Information *(Complete questions A through J. 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(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire) _____

_____

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, 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 any driving violations to include driving under the influence of alcohol or drugs? ☐ yes ☐ no

*(If yes, list date, state, license #, 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, county, state, charge, and current status)* _____

_____

_____

G. Is any Proposed Insured an active duty service member of the US Armed Forces, a member of the National Guard or an active reservist of the US Armed Forces, or a dependent of an active duty service member of the US Armed Forces? ☐ yes ☐ no

(If yes, provide Pay Grade, Rank and any known foreign assignments. Complete the applicable Military Disclosure)

_____

_____

H. 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

I. 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

J. 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

(If yes, describe the incentive) _____

_____

Remarks

16. Details and Explanations_____

_____

_____

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

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) to the best of my knowledge and belief 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 questions regarding any Proposed Insured's health and age in section 3 of the LTLIA; 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).

Owner signed at (city, state) _____ On (date) _____

Owner Signature X _____ **Title** _____
(If Corporate Officer or Trustee)

Primary Proposed Insured Signature (if other than Owner) **X** _____
(If under age 15, signature of parent or guardian)

Other Proposed Insured Signature (if other than Owner) **X** _____
(If under age 15, signature of parent or guardian)

Agent(s) Signature(s)
I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* Sofia Baghaeimehr Writing Agent # _____

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

Agent's Report

1. Statements

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

B. If yes to question 1 A., do you have any information that any Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for? ☐ yes ☐ no
(*If yes, please provide details in the Remarks section below and attach replacement-related forms)*

C. Number of years you have known Primary Proposed Insured: _____
Other Proposed Insured: _____

D. 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

E. 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
			%
			%
			%
			%

4. Agent Agreement and Signature

I understand and agree that if I am made aware of any changes to any of the answers contained in any of the forms I will notify the company of the changes.

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

Writing Agent Signature **X** _____

State License # _____ Phone # 8189330000

Email sofiainsurance@aol.com Fax # 800-508-2971

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 and Inforce Operations

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 to give American General Life Insurance Company of Delaware, American General Life Insurance 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.

LEAVE THIS FORM WITH THE PROPOSED INSURED(S)

NOTICES TO THE PROPOSED INSURED(S)

American General Life Insurance Company, Houston, TX

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

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.

FAIR CREDIT REPORTING ACT AND INVESTIGATIVE CONSUMER REPORTING AGENCIES ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), and your state's Investigative Consumer Reporting Agencies Act, notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that could include information about your character, general reputation, personal characteristics and mode of living, from one of the following consumer reporting agencies:

Systematic Business Services, Inc.,
10101 Renner Boulevard,
Lenexa, KS 66219-9752, 800-444-7274

Portamedic,
170 Mt. Airy Rd.,
Basking Ridge, NJ 07920, 800-444-3737

Examination Management Services, Inc.,
3003 LBJ Freeway, Suite 200,
Dallas, TX 75234, 800-USA-EMSI

If an investigative consumer report is ordered a copy will be provided to you within three (3) days after our receipt of the report.

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.

LEAVE COMPLETED AND SIGNED FORM WITH THE OWNER

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. To the best of your knowledge and belief has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system (excluding HIV tests), 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. To the best of your knowledge and belief 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 _____
(If under age 15, signature of parent or guardian)

Signature of Other Proposed Insured *(if applicable)*_____ Date _____
(If under age 15, signature of parent or guardian)

Writing Agent Name *(please print)* Sofia Baghaeimehr Writing Agent # _____

SUBMIT COMPLETED FORM WITH 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. To the best of your knowledge and belief has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system (excluding HIV tests), 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. To the best of your knowledge and belief 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.

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- 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 _____
(If under age 15, signature of parent or guardian)

Signature of Other Proposed Insured *(if applicable)* _____ Date _____
(If under age 15, signature of parent or guardian)

Writing Agent Name *(please print)* Sofia Baghaeimehr Writing Agent # _____