American General
Life Companies

Life Insurance Application
Part B
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.

Personal Information

1. Proposed Insured *(Complete separate Part B for each Proposed Insured)*

First Name _____ MI _____ Last Name _____ Date of Birth _____ Social Security # _____

Medical History

(Instructions: Please answer ALL medical history questions. Do not leave any questions blank.)

2. Physician Information

Name, address and phone number of the Proposed Insured's personal physician(s). *(If no personal physician, provide name, address and phone # of doctor last seen)*

Name _____ Phone ( ) _____

Address _____ City, State _____ ZIP _____

Date, reason, findings and treatment at last visit _____

_____

_____

_____

_____

3. Build

A. Admitted Height and Weight _____ ft _____ in _____ lbs

(Examiners: Also record measured height and weight on Exam page 1)

B. Has the Proposed Insured had any weight change in excess of 10 lbs in the **past year**? ☐ yes ☐ no If yes, complete the following:

Loss _____ lbs Gain _____ lbs Reason _____

If weight change was due to pregnancy, provide due/delivery date _____

4. Family History

Age if Living	Age at Death	Cause of Death	History of Heart Disease?	History of Cancer?
Father _____	_____	_____	☐ no ☐ yes _____ Age of Onset	☐ no ☐ yes _____ Age of Onset Type _____
Mother _____	_____	_____	☐ no ☐ yes _____ Age of Onset	☐ no ☐ yes _____ Age of Onset Type _____

5. Personal Health History

A. Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a licensed health care provider for:

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

2) a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☐ no

3) cancer, tumors, masses, cysts or other such abnormalities? ☐ yes ☐ no

4) 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

5) colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? ☐ yes ☐ no

6) a disorder of the kidneys, bladder, prostate or reproductive organs or protein in the urine? ☐ yes ☐ no

7) asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? ☐ yes ☐ no

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

9) arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? ☐ yes ☐ no

(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details_____

_____

_____

_____

_____

_____

_____

B. Is the Proposed Insured currently taking any medication, treatment or therapy or under medical observation? ☐ yes ☐ no

(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details_____

_____

_____

C. Has the Proposed Insured in the **past three years** had but NOT sought treatment for:

1) fainting spells, nervous disorder, headaches, convulsions or paralysis? ☐ yes ☐ no

2) any pain or discomfort in the chest or shortness of breath? ☐ yes ☐ no

3) disorders of the stomach, intestines or rectum, or blood in the urine? ☐ yes ☐ no

(If yes, list condition such as: date of first occurrence; symptoms; and how treated)

Details_____

_____

_____

D. Has the Proposed Insured **ever**:

1) sought or received medical advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? ☐ yes ☐ no

2) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? ☐ yes ☐ no

(If yes answered to D1 or D2, please provide details below)

Type of drug(s)/alcohol product(s) _____ Date last used _____

Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly Amount usually used: _____

Name(s) of doctor/facility _____ Phone ( ) _____

Address _____ City, State _____ ZIP _____

Treatment Dates _____

Support group(s) _____ Last date attended _____

Was treatment or support group attendance court ordered? ☐ yes ☐ no

Details of any drug or alcohol related arrests _____

5. Personal Health History *(continued)*

E. Has the Proposed Insured **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

(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details_____

F. Other than previously stated, in the **past 10 years**, has the Proposed Insured:

1) been hospitalized, consulted a health care provider or had any illness, injury or surgery? ☐ yes ☐ no

(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details_____

2) been advised to have any diagnostic test (excluding HIV tests), hospitalization or treatment that was NOT completed? ☐ yes ☐ no

(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; recommended tests, medications or treatment)

Details_____

3) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition? ☐ yes ☐ no

(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details_____

G. Has the Proposed Insured had any emergency room or emergency clinic visits during the **past 5 years**? ☐ yes ☐ no

(If yes, provide name and address of hospital or emergency clinic, reason for visit(s), and resolution of condition)

Details_____

H. Does the Proposed Insured have any symptoms or knowledge of any other condition that is NOT disclosed above? ☐ yes ☐ no

(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details_____

Agreement and Signatures

I, the Proposed Insured 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.

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).

Fraud

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.

SIGNATURE OF PROPOSED INSURED

Signed at *(city, state)* _____ On *(date)* _____

X _____

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

SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part B application.

If Agent recorded information

Sofia Baghaeimehr _____ _____ _____

Writing Agent Name *(Please print)* | Writing Agent # | Date

X _____ **X** _____

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

If Tele-interviewer recorded information

_____ _____ _____

Name *(Please print)* | Company | Date

If Paramedical Examiner/Medical Doctor recorded information

Examiner Address _____ **Paramed: Use company stamp below.**

Examiner Phone # ( ) _____

Examiner Name _____

Examiner Signature

X _____ Date _____

Physical Measurements

1. Proposed Insured

A. Name _____

B. Build: Measured Height *(in shoes)* _____ ft _____ in Weight *(clothed)* _____lbs *(Please weigh insured)*
If unable to obtain accurate weight, please provide reason _____

C. Blood Pressure *(three readings required)*: If blood pressure exceeds 140/90, repeat reading at end of examination.*
Select cuff size: ☐ Standard BP cuff ☐ Large BP cuff

	1st Reading	2nd Reading	3rd Reading	*Repeat Reading
Systolic BP				
Diastolic 5th Phase BP				
Pulse Rate				
Irregularities Per Min.				

D. Did you weigh Proposed Insured? ☐ yes ☐ no

E. Have any of the following been completed in conjunction with this exam?
☐ Blood ☐ Urine ☐ EKG ☐ Stress Test

F. Is appearance unhealthy or older than stated age? ☐ yes ☐ no

G. Do you have any pertinent information not disclosed previously? ☐ yes ☐ no
(Details of yes answers to questions F and G)

_____
_____
_____

H. Are you related to the Proposed Insured by blood or marriage or do you have any business or professional relationship with the Proposed Insured? *(If yes, explain)* ☐ yes ☐ no

_____
_____

Report By Examining Medical Doctor

Instructions to doctor:

To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1) Heart

a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? _____ ☐ yes ☐ no

b. Is heart enlarged? *(If yes, describe)* _____ ☐ yes ☐ no

c. Is murmur present? *(If yes, complete 1d)* _____ ☐ yes ☐ no

d. Before exercise, murmur is:

☐ Constant Transmitted to where? _____

☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere

☐ Systolic *(Give details)* _____

☐ Diastolic Murmur grade: *(Please circle)* 1/6 2/6 3/6 4/6 5/6 6/6

After valsalva, murmur is:

☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

Your impression _____

_____
_____

Report by Examining Medical Doctor *(continued)*

2) Has this examination revealed any abnormality of the following: *(Provide details to yes answers below)*

a) Eyes, ears, nose, mouth and throat? *(If vision or hearing is markedly impaired, indicate degree and correction)* ☐ yes ☐ no

Details_____

_____

_____

b) Endocrine system *(including thyroid)*? ☐ yes ☐ no

Details_____

_____

_____

c) Nervous system *(including reflexes, gait, paralysis)*? ☐ yes ☐ no

Details_____

_____

_____

d) Respiratory system? ☐ yes ☐ no

Details_____

_____

_____

e) Abdomen *(including scars)*? ☐ yes ☐ no

Details_____

_____

_____

f) Genito-urinary system? ☐ yes ☐ no

Details_____

_____

_____

g) Skin *(including scars)*, lymph nodes, blood vessels *(including varicose veins)*? ☐ yes ☐ no

Details_____

_____

_____

h) Musculoskeletal system *(including spine, joints, amputations, deformities)*? ☐ yes ☐ no

Details_____

_____

_____

Signature

Paramedical Examiner/Medical Doctor Signature

I certify that this exam was conducted the _____ day of _____ , 20 _____, at _____ ☐ am ☐ pm

Location of Exam _____ **Paramed: Use company stamp below.**

Examiner Address _____

Examiner Phone # ( ) _____

Examiner Name _____

Examiner Signature **X** _____

(Agent should inform Paramedical Examiner/Medical Doctor of proper location to send form upon completion)