American General
Life Companies

Reinstatement Application for Life Insurance
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

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.

Policy Number(s) _____

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. 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

C. 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
2. Name and address of personal physician

   Primary Insured: _____

   Other Insured: _____
3. Date, reason, findings and treatment at last visit

   Primary Insured: _____

   Other Insured: _____

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: _____

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 or court records, 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 reinstatement of my coverage. I understand that any misrepresentation contained in this application and related forms and relied on by 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 unless or until approved for reinstatement, the full reinstatement premium for the 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.

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)

Sofia Baghaeimehr

Agent Name (printed) **Agent Signature**

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)