



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

Member companies of American International Group, Inc.

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. Primary Proposed Insured

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 If yes, date of last use \_\_\_\_\_  
 If yes, type and quantity of tobacco or nicotine products used \_\_\_\_\_  
 Driver's License  yes  no Number \_\_\_\_\_ License State \_\_\_\_\_  
 U.S. Citizen  yes  no If no, Date of Entry \_\_\_\_\_ Visa Type \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Duties \_\_\_\_\_  
 Personal Earned Income \$ \_\_\_\_\_ Household Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_  
 If Primary Proposed Insured is a child or is age 18 or over and not self-supporting, what amount of insurance is in force on any of the following: Spouse \$ \_\_\_\_\_ Father \$ \_\_\_\_\_ Mother \$ \_\_\_\_\_ Siblings \$ \_\_\_\_\_

2. Other Proposed Insured

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 If yes, date of last use \_\_\_\_\_  
 If yes, type and quantity of tobacco or nicotine products used \_\_\_\_\_  
 Driver's License  yes  no Number \_\_\_\_\_ License State \_\_\_\_\_  
 U.S. Citizen  yes  no If no, Date of Entry \_\_\_\_\_ Visa Type \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Duties \_\_\_\_\_  
 Personal Earned Income \$ \_\_\_\_\_ Household Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_

Ownership

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

Name \_\_\_\_\_ Social Security or Tax ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home Phone ( ) \_\_\_\_\_ Relationship to Primary Proposed Insured \_\_\_\_\_  
 Email \_\_\_\_\_

B. Complete if Owner is a trust (If trustee is premium payor, also complete section 14 D.)

Exact Name of Trust \_\_\_\_\_ Trust Tax ID # \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Email \_\_\_\_\_  
 Current Trustee(s) \_\_\_\_\_ Date of Trust \_\_\_\_\_

\*for identification purposes only

**Product Information**

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. **Dividend Options** (For participating policy only.)  
 Cash  Premium Reduction  Paid-up Additions  Deposit Earning Interest  Other (Explain) \_\_\_\_\_

6. **Premium Allocation** (For Indexed UL only if applicable.)  
Indicate how each premium received is to be allocated. **Total allocations must equal 100%. Use whole percentage only.**  
Indexed Interest Account \_\_\_\_\_% Excess Interest Account \_\_\_\_\_% Total 100%

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

8. **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 \$ \_\_\_\_\_  
 Disability Income Rider (Complete the following if DI Rider is requested)  
Number of Units (1 unit = \$100): \_\_\_\_\_ Occupational Class (Please check):  1  2  
 Adjustable Return of Premium Rider - (Provide % of Premium) \_\_\_\_\_  
 Scheduled Increase Rider  
 Other Riders/Benefits #1 \_\_\_\_\_ Amount/Unit(s) \_\_\_\_\_  
 Other Riders/Benefits #2 \_\_\_\_\_ Amount/Unit(s) \_\_\_\_\_

**Beneficiary**

9. **Primary** Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%

10. **Contingent** Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%

11. **Trust Information (if Beneficiary)** Exact Name of Trust \_\_\_\_\_  
Trust Tax ID # \_\_\_\_\_ Current Trustee(s) \_\_\_\_\_ Date of Trust \_\_\_\_\_

12. **Rider Beneficiaries** (Complete if other than Primary Proposed Insured.)  
Other Insured/Spouse Rider \_\_\_\_\_ Relationship \_\_\_\_\_  
Child Rider \_\_\_\_\_ Relationship \_\_\_\_\_

**Business Coverage**

13. **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  
Describe any special circumstances. \_\_\_\_\_

**Premium**

- 14. 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.)*
- Other *(Please explain.)* \_\_\_\_\_
- C. Amount submitted with application \$** \_\_\_\_\_
- D. Premium Payor** *(Complete if other than Owner.)*
- Name \_\_\_\_\_ Social Security or Tax ID # \_\_\_\_\_
- Relationship to Primary Proposed Insured \_\_\_\_\_
- Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

**Limited Temporary Life Insurance Eligibility**

- 15. Health and Age Questions** *(Regarding the Primary Proposed Insured and the Other Proposed Insured under a joint life or survivorship policy, if the correct answer to either question below is "yes" or any question is answered falsely or left blank, coverage is not available under the Limited Temporary Life Insurance Agreement ("LTLIA") and it is void, and any payment submitted will be refunded. Read the LTLIA for additional terms and conditions of coverage.)*
- A.** Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, 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?    yes    no
- B.** Is any Proposed Insured age 71 or above?    yes    no

**Existing Coverage**

**16. Existing Coverage**

**A. Life and Annuity Coverage**

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

*(If yes, complete the following regarding such annuities or life insurance policies.)*

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

Name of Proposed Insured	Policy Number	Insurance Company	Type(s) <i>(see above)</i>	Year of Issue	Face Amount	Replace*	1035 Ex
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes

\***Replace** means that the insurance being applied for may replace, change or use any monetary value of any existing or pending life insurance policy or annuity. If replacement may be involved, complete and submit replacement-related forms. Please note: 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.

**B. 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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Nonmedical Questions**

**17. Background Information** *(Complete questions A through F. 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, date, length of stay and purpose.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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, circle or list the applicable activities and 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 driving under the influence of alcohol or drugs or had any driving violations?  yes  no

*(If yes, list date, state, license no. 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, state and charge.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Remarks**

**18. Details and Explanations** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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) 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 Health and Age Questions in section 15; 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).

**Proposed Insured(s)/Owner Signature**

Signed at (city, state) \_\_\_\_\_ On (date) \_\_\_\_\_

Primary Proposed Insured **X** \_\_\_\_\_  
*(If under age 15, signature of parent or guardian)*

Other Proposed Insured **X** \_\_\_\_\_  
*(If under age 15, signature of parent or guardian)*

Owner *(If other than Primary Proposed Insured)* **X** \_\_\_\_\_

**Agent(s) Signature(s)**

I certify that the information supplied by the Primary Proposed Insured(s)/Owner has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* \_\_\_\_\_ Writing Agent # \_\_\_\_\_

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

**Agent's Report**

**1. Statements**

- A. Number of years you have known Primary Proposed Insured: \_\_\_\_\_  
Other Proposed Insured: \_\_\_\_\_
- B. Does any Proposed Insured have any existing or pending annuities or life insurance policies?  yes  no  
If yes, do you have any information that indicates that any Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity with any company in connection with the purchase of insurance?  yes  no  
*(If yes, please provide details in the Remarks section below and attach all replacement-related forms. 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.)*
- C. 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
- D. 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
_____	_____	_____	_____%
_____	_____	_____	_____%
_____	_____	_____	_____%
_____	_____	_____	_____%

Writing Agent Name *(Please print)* \_\_\_\_\_ Date \_\_\_\_\_  
Writing Agent Signature **X** \_\_\_\_\_  
State License # \_\_\_\_\_ Phone # \_\_\_\_\_  
Email \_\_\_\_\_ Fax # \_\_\_\_\_

**For Home Office use**

Processing Center \_\_\_\_\_ Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_  
Servicing Agent (if other than writing agent) send policy/delivery requirements to \_\_\_\_\_  
\_\_\_\_\_



