



- Insurance company selection checkboxes: 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

Form fields for Primary Proposed Insured: Name, Social Security #, Sex, Birthplace, Date of Birth, Current Age, Tobacco Use, Driver's License, U.S. Citizen, 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.

2. Other Proposed Insured

Form fields for Other Proposed Insured: Name, Social Security #, Sex, Birthplace, Date of Birth, Current Age, Relationship to Primary Proposed Insured, Tobacco Use, Driver's License, U.S. Citizen, 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.)

Form fields for Section 3.A: 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.)

Form fields for Section 3.B: 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**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

