



- 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. Proposed Insured (Complete separate Part B for each Proposed Insured)

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 number 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 _____

4. Family History

Age if Living	Age at Death	Cause of Death	History of Heart Disease?	History of Cancer?
Father _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Mother _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Brother _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Brother _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Sister _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____ Type _____
Sister _____	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> 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? 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 sugar 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 a mental or nervous disorder? 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 number 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 number 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 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 _____
Name(s) of doctor/facility _____ Phone () _____
Address _____ City, State _____ ZIP _____
Treatment Dates _____
Support group(s) _____ Last date attended _____
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 number 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 number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

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

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

Details _____

G. 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 number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

