



- Insurance company selection options: 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.

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, Address, Home Phone, Work Phone, Email, Employer, Occupation, Length of Employment, Employer Address, Duties, Personal Earned Income, Household Income, Net Worth, and insurance amounts for spouse, father, mother, and siblings.

2. Owner

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

Form fields for Owner 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 8 D.)

Form fields for Owner B: Exact Name of Trust, Trust Tax ID #, Address, City, State, ZIP, Email, Current Trustee(s), Date of Trust

3. Plan of Insurance

Form fields for Plan of Insurance: Product Name, Amount Applied For \$, Premium Class Quoted, Reason for Insurance

Riders/Benefits

Form fields for Riders/Benefits: Child Rider, Waiver of Premium, Accidental Death Benefit, Disability Income Rider, Other Riders/Benefits #1, Other Riders/Benefits #2

\*for identification purposes only

4. **Primary Beneficiary** Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%

5. **Contingent Beneficiary** Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%

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

7. **Business Insurance Details** (Complete only if applying for business coverage.)  
 Does the Primary Proposed Insured have an ownership interest in the business?  yes  no  
 If yes, what is the percentage of ownership for the Primary 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. \_\_\_\_\_

8. **Premium Payment**  Modal \$ \_\_\_\_\_  
**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.) Relationship to Primary Proposed Insured \_\_\_\_\_  
 Name \_\_\_\_\_  
 Social Security or Tax ID # \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

9. **Health and Age Questions** (Regarding the Primary Proposed Insured, 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 the Primary 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 the Primary Proposed Insured age 71 or above?  yes  no

10. **Existing Coverage**

**A. Life and Annuity Coverage**  
**Does the Primary 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

| Policy Number | Insurance Company | Type(s)<br>(see above) | Year of Issue | Face Amount | Replace*   |
|---------------|-------------------|------------------------|---------------|-------------|--|
| _____         | _____             | _____                  | _____         | _____       | <input type="checkbox"/> yes <input type="checkbox"/> no |
| _____         | _____             | _____                  | _____         | _____       | <input type="checkbox"/> yes <input type="checkbox"/> no |
| _____         | _____             | _____                  | _____         | _____       | <input type="checkbox"/> yes <input type="checkbox"/> no |
| _____         | _____             | _____                  | _____         | _____       | <input type="checkbox"/> yes <input type="checkbox"/> no |

\***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.

**10. Existing Coverage (continued)**

**B. Disability Coverage (Complete only if Disability Income Rider coverage requested.)**

Does the Primary Proposed Insured have any existing or pending Disability insurance policies?  yes  no

(If yes, complete the following regarding existing or pending disability insurance)

| Insurance Company | Benefit Amount | Benefit Period | Elimination Period | Year Issued |
|-------------------|----------------|----------------|--------------------|-------------|
|                   |                |                |                    |             |

**11. Background Information (Complete questions A through F. If yes answer applies to the Primary Proposed Insured, provide details specified after each question.)**

**A.** Does the Primary 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 the Primary 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 the Primary 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 the Primary 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 the Primary 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 the Primary 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**

**12. Details and Explanations** \_\_\_\_\_

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

