AMERICAN GENERAL

Term Insurance Application
Part A
South Carolina Version

☐ **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.

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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 $ ______________

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2. Owner

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 8 D.)*

Exact Name of Trust ______________ Trust Tax ID # ______________

Address ______________ City, State ______________ ZIP______________

Email ______________

Current Trustee(s) ______________ Date of Trust ______________

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3. Plan of Insurance

Product Name ______________ Amount Applied For $ ______________

Premium Class Quoted______________ Reason for Insurance ______________

Riders/Benefits

☐ Child Rider Amount $ ______________ **(Complete Child Rider Attachment)** or ☐ No current children

☐ Waiver of Premium ☐ Accidental Death Benefit Amount $ ______________

☐ Disability Income Rider *(Complete the following if DI Rider is requested)*

Number of Units *(1 unit = $100):* ______________ Occupational Class *(Please check):* ☐ 1 ☐ 2

☐ Other Riders/Benefits #1______________ Amount/Unit(s) ______________

☐ Other Riders/Benefits #2______________ Amount/Unit(s) ______________

**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) *(see above)*	Year of Issue	Face Amount	Replace*
__________	______________________	________	________	________	☐ yes ☐ no
__________	______________________	________	________	________	☐ yes ☐ no
__________	______________________	________	________	________	☐ yes ☐ no
__________	______________________	________	________	________	☐ yes ☐ 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 ______