



- American General Life Insurance Company, Houston, TX
The United States Life Insurance Company in the City of New York, New York, NY (Non-NY Residents)
Members of American International Group, Inc.
P.O. Box 4373 • Houston, TX 77210-4373

The insurance company checked above is solely responsible for the obligation and payment of benefits under any policy it may issue. No other company shown is responsible for such obligations or payments.

Use permanent ink when completing this form. Be sure to answer all questions that pertain to your request. Provide details for any questions answered "Yes". Personally sign and date. If a separate page is needed to complete the answers, attach to this form and sign and date the separate page(s). Carefully read the attached Notice of Information Practices and keep with your policy.

Policy Number Insured Name

Reinstatement or Reduction of Premium Rate

SECTION I - GENERAL INFORMATION:

A. PRIMARY INSURED

Name Social Security # Sex M F
Birthplace (state, country) Date of Birth Age
U.S. citizen Yes No If no, date of entry Visa Type
Address City, State Zip
Home Phone Work Phone
Email address
Employer Occupation
Length of Employment Duties
Personal Income \$ Household Income \$ Net Worth \$

B. OWNER INFORMATION

Primary Insured Other Insured Trust Someone other than an insured or trust
Complete if other than the primary insured is owner (If contingent owner is required, use Special Remarks section.)
Name Tax ID #

Check here if new address

Address City, State Zip
Home Phone Work Phone

If owner is a trust please designate information for the Name, Tax ID, Current Trustee and Date of Trust in the Special Remarks section.

C. OTHER INSURED(S): Please add information for all additional insureds.

Name Social Security # Sex M F
Birthplace (state, country) Date of Birth Age
U.S. citizen Yes No If no, date of entry Visa Type
Address City, State Zip
Home Phone Work Phone
Email address
Employer Occupation
Length of Employment Duties
Personal Income \$ Household Income \$ Net Worth \$

D. CHILD INFORMATION (Complete information for all children covered by child rider.)

Child Name	Sex	Birthplace (state, country)	Date of Birth
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____

E. BILLING

Frequency: Annual Semi Annual Quarterly Monthly Other
Method: Direct List bill Automatic bank draft Other _____
Payment Enclosed: Yes No Amount _____ Check # _____
Effective date (if applicable): _____

F. BENEFICIARY – The beneficiary at the time the policy was last in force will be continued or reinstated. To change the beneficiary please attach your signed request.

SECTION II:

A. BACKGROUND INFORMATION – For all covered persons

Complete questions 1 through 8 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details.

1. 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 _____
2. Have you ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? Yes No
3. Have you ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? Yes No
4. Driver's License No.: _____ State: _____
In the past five years, have you been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? Yes No
5. In the past five years have you participated in or intend to participate in any flights as a trainee, pilot or crew member? If yes, submit appropriate questionnaire. Yes No
6. In the past five years, have you participated in or intend to participate in any hazardous sports such as scuba diving, skydiving, parachuting, ultralight aviation, auto racing, cave exploration, hang gliding, boat racing, mountaineering, extreme sports or hazardous activities? If yes, submit appropriate questionnaire. Yes No
7. Do you intend to travel or reside outside the United States or Canada within the next two years? Yes No
8. Have you ever requested or received a pension, benefits, or payments because of an injury, sickness, or disability? Yes No

Details: _____

B. NON MEDICAL INFORMATION

1. Height ____Ft. ____In. 2. Weight ____ lbs. Change of weight in last year? None Gain: ____ lbs. Loss: ____ lbs.
3. Name and address of your personal physician. (Write *none* if you do not have one.)

4. Date, reason, findings and treatment at last visit. _____

C. MEDICAL INFORMATION

Complete questions 1 through 4 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details such as date of first diagnosis, name and address of doctor, tests performed, test results, medication(s) or recommended treatment.

1. Have you ever been diagnosed as having or been treated for, or consulted a licensed health care provider for:

- a. High blood pressure, diabetes, cancer, tumor, epilepsy, asthma, emphysema, or any disorder of the heart or of the blood vessels? Yes No
- b. Disease or disorder of the stomach, intestines, liver, pancreas, lungs, kidneys, urinary tract, brain, prostate, lymph glands, or reproductive organs? Yes No
- c. Mental or nervous condition or disorder of bones, muscles, or joints? Yes No

Details: _____

2. Have you ever been diagnosed or treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? (If yes, explain) Yes No

Details: _____

3. Are you currently taking any medication, treatment or therapy or under medical observation? Yes No

Details: _____

4. Do you have any symptoms or knowledge of any other condition that is not disclosed above? Yes No

Details: _____

D. SPECIAL REMARKS: Use this space to provide any additional comments or remarks not given in detail above.

STATE SPECIFIC NOTICES

Please note the following state specific information.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denials of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

AUTHORIZATION AND SIGNATURES**American General Life Insurance Company, Houston, TX****The United States Life Insurance Company in the City of New York, New York, NY**

In this application, "Company" refers to the insurance company which was selected on page one.

Authorization to Obtain and Disclose Information and Declaration

I give my consent to all of the entities listed below to give to the Company, its legal representative, American General Life Companies (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations, treatments or surgeries; hospital confinements for any physical and mental conditions; use of drugs or alcohol; 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 or court records, 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; 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 or changes to 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 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 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.

I have read the above statements 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 shall be the basis for: (1) any policy issued; or (2) changes to the existing policy as requested on this application. I understand that any misrepresentation contained in this application and related forms and relied on by Company may be used to reduce or deny a claim or void the policy, if it is within its contestable period and if such misrepresentation materially affects the acceptance of the risk. I understand and agree that no insurance will be in effect under this application, or under any new policy issued by the Company, unless or until: the policy has been delivered and accepted; the first full modal premium for the issued policy has been paid; and there has been no change in the health of any proposed insured that would change the answers to any questions in the application.

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 of the Notice of Information Practices.

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).

Any person who, with intent to defraud or facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Special Circumstances- Corporate Ownership: The signature of one officer followed by the officer's title is required. The request must be submitted on: (1) corporate letterhead; (2) or paper with the corporate seal signed by that officer. Partnership: Provide the full name of the partnership followed by the signatures of all partner(s), other than the Insured. Trust: If the contract is owned by or assigned to a Trustee, Trustee(s) signature are required as instructed by the trust agreement. Validation of Trustee(s) signature may be required.

Signed at (City and State)

Date

Signature of Primary Insured (if under age 15, signature of parent or guardian)

Signature of Other Insured (if under age 15, signature of parent or guardian)

Signature of Owner (if other than insured)

Signature of Officer and Title (if corporate owned)

Signature of Trustee (if owned by a trust)

Agent Signature

Date

Agent Name (Printed)

State License #

NOTICE OF INFORMATION PRACTICES**American General Life Insurance Company, Houston, TX****The United States Life Insurance Company in the City of New York, New York, NY**

You have applied for life insurance with one of the insurance companies identified above. "Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies (AGLC), (a company providing services to affiliated life insurance companies that are members of American International Group Inc.)

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living. This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P. O. Box 1931

Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

Medical Information Bureau

The designated insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you. At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address and phone number of the MIB's information office are:

P. O. Box 105

Essex Station

Boston, Massachusetts 02112

617/426-3660

The designated insurer, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization, as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding. Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information. If you desire additional information on insurance information practices, you should direct your requests to the Company at:

P. O. Box 1931

Houston, TX 77251-1931

Telephone Interview Information

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

*** PLEASE READ AND KEEP WITH YOUR POLICY***