



- Checkboxes for insurance companies: American General Life Insurance Company, The United States Life Insurance Company in the City of New York, AIG Life Insurance company, American International Life Assurance Company, New York, AIG Life Insurance Company of Puerto Rico

Member companies of American International Group, Inc. P.O. Box 4373 • Houston, TX 77210-4373

In this request, "Company" refers to the insurance company whose name is checked above. The insurance company checked above is solely responsible for the obligation and payment of benefits under any policy it may issue.

Instructions:

- This form is used to elect GIO Options and to request full or partial term conversions for a Primary insured on an inforce single life policy and/or rider where evidence of insurability is NOT required. This form is NOT to be used when evidence of insurability is required.
• IF ADDITIONAL INSURANCE OVER THE CONVERSION AMOUNT IS REQUESTED OR RIDERS OR BENEFITS THAT REQUIRE EVIDENCE OF INSURABILITY ARE REQUESTED, PLEASE COMPLETE THE INFORCE CHANGE APPLICATION FOR THE APPLICABLE STATE.

Please fax form to: 1-800-382-4662.

CURRENT POLICY # \_\_\_\_\_ INSURED NAME \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE \_\_\_\_\_ ZIP \_\_\_\_\_

REQUESTED CHANGE

Benefits: If the insured meets the "total disability" definition in the Waiver of Premium provision, the insured may not be eligible to convert to or include Waiver of Premium on the new policy.

Term Conversion

CONVERSION AMOUNT

Base coverage: \_\_\_\_\_

Supplemental Coverage: \_\_\_\_\_

Effective date: \_\_\_\_\_

New Plan: \_\_\_\_\_

Death Benefit Option (Universal Life plans only):

- Level Increasing Level Plus Return of Premium

After the conversion, will there be any remaining coverage on the existing policy? Yes No

Amount remaining after conversion: \_\_\_\_\_

Exercise Guaranteed Insurability Option (GIO)

GIO amount: \_\_\_\_\_

Option Date: \_\_\_\_\_

GENERAL INFORMATION

A. Owner Information

Name \_\_\_\_\_ Tax ID #/Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Complete if owner is a trust:

Exact Name of Trust \_\_\_\_\_ Trust Tax ID # \_\_\_\_\_

Current Trustee(s) \_\_\_\_\_ Date of Trust \_\_\_\_\_

Payor address if different from Owner

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

**B. Beneficiary – COMPLETION REQUIRED**

The undersigned contract owner hereby revokes any previous beneficiary designation on the coverage being converted as well as optional mode of settlement with respect to any death benefit proceeds payable at the death of the insured under the new policy. If this conversion or GIO transaction results in coverage remaining under the current policy number, beneficiary designations of record for that policy will be retained.

*Primary:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ % Share \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ % Share \_\_\_\_\_

*Contingent:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ % Share \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ % Share \_\_\_\_\_

*Trust Information:*

Exact Name of Trust \_\_\_\_\_ Trust Tax ID \_\_\_\_\_

Current Trustee(s) \_\_\_\_\_ Date of Trust \_\_\_\_\_

*Rider Beneficiaries:*

Spouse Rider \_\_\_\_\_ Relationship \_\_\_\_\_

Child Rider \_\_\_\_\_ Relationship \_\_\_\_\_

**C. Billing**

Frequency:  Annual  Semi Annual  Quarterly  Monthly (Bank Draft Only)

Method:  Direct  List bill  Bank draft (complete and submit EFT Authorization)  Government Allotment

Payment Enclosed:  Yes  No Amount \_\_\_\_\_ Check # \_\_\_\_\_

**AUTHORIZATION AND SIGNATURES**

I understand and agree that no insurance will be in effect under this request, or under any new policy issued by the Company, unless or until: the policy has been delivered and accepted and the first full modal premium for the issued policy has been paid.

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.

**Under penalties of perjury, I certify: (1) that the number shown on this request 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).**

Signed at (City and State) \_\_\_\_\_

Date \_\_\_\_\_

**Signature of Owner**

**Special Requirements - Corporate Ownership:** The signature of one officer followed by the officer's title is required. In addition, a separate request for this transaction must be submitted on: (1) corporate letterhead; or (2) 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 Trust, Trustee(s) signature is required. Validation of Trustee(s) signature may be required.

**Agent Signature**

**Date**

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split	Broker-Dealer (if variable)
_____	_____	_____	_____	<input type="checkbox"/> AGSI
_____	_____	_____	_____	<input type="checkbox"/> Other: _____
_____	_____	_____	_____	<input type="checkbox"/> AGSI
_____	_____	_____	_____	<input type="checkbox"/> Other: _____

**Agent/Agency Telephone #**

**Fax #**

**Email Address**

