TOOLS & TIPS • tip sheets •

# Tips for Accelerated Application & Compliant Replacement Processing

Complete, detailed, legible information can improve the application to issue timing. Shown below are key data elements and forms that will help to ensure an in good order application and minimize app to issue turnaround time.

**Coversheet/Transmittal** – Please provide:

- Contact name, phone, and e-mail address
- Companion and/or Alternate/Additional policies, if applicable
- Special issue or other instructions

**Part A –** Please provide or complete in legible handwriting or typed -- e.g., capital letters and no cursive handwriting:

- Correct state version of application and all forms required. Should match the state in which the owner has signed.
- Name, address and date of birth
- Social Security number (insured and owner SSN needed, if different parties)
- Birthplace
- All tobacco use questions answered completely
- Driver's license number and state, if applicable; Questions must be answered if applicant is over 16 years of age
- All employer and employment information
- All income specified
- Citizenship information
- Owner information, if different than applicant
- Beneficiary information
- Entity Information / Trust ID for owner
- Plan name and term, if applicable
- Face amount for insured, any riders requested, and Premium Class Quoted
- Premium frequency, mode, and method
- Bank draft and/or void check provided for monthly payment, if applicable
- Initial Premium Received – if yes, Limited Temporary Life Insurance (LTLIA) may be applicable; See Other Forms section below.
- All payor information including SSN, if payor different than applicant/owner
  - If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form
- All replacement information must be received
  - Existing coverage, (insuring) company name and face amount
  - NAIC replacement form for NAIC states is other coverage exists
  - Correct state required replacement form(s) received, must be signed and dated on or before the Part A
  - Refer to the Replacement Section of this form for additional, more detailed information.
- All background information questions answered with complete details or applicable questionnaires provided for any "Yes" answers
- Signatures of Insured & Owner (if owner is different than insured)
- City/State/Date of signing
- Agent's signature
- All pages of application and supplemental forms (see below for more info on commonly needed forms)

**Other Forms –** (varies by product, coverage requested and state) – Please provide or complete:

- State required HIV forms
- HIPAA authorization with applicant signature
- Agent Report
  - Agent questions, agent/agency codes and agent signature are required
  - Answer 'yes' or 'no' to the inforce and/or pending coverage question (must match answer on Part A)
  - Answer 'yes' or 'no' to the coverage being replaced question (must match answer on Part A)
  - License number, agent phone number, email and fax number
- Paramedical Exam with lab slip or Part B, if required
  - Must be on the same state form as Part A; All questions answered with details provided for any 'Yes' answers
- Child Rider Supplement, if applying for Child coverage
- Index Universal Life Supplement, if applying for an indexed universal life product

- Limited Temporary Life Insurance (LTLIA) Agreement,
  - If eligible for LTLIA, collect initial premium and complete agreement; LTLIA is given to applicant and copy or duplicate original is returned to American General.
  - If not eligible for LTLIA, do NOT collect initial premium and do NOT complete LTLIA.
- Illustration or quotation, when applicable
  - Must match application information
- State applicable disclosure forms

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**Replacement Section –** Shown below are 3 critical areas of focus -

**Existing Coverage Information**

- Answer 'yes' or 'no' to the inforce or pending policies question. (A); If 'yes',
  - Provide Policy Number or write 'Unknown' in the Policy Number field (B)
  - Provide name of existing insurer in Company Name field (C)
  - Provide face amount of existing coverage in the Amount of Coverage field (D)
  - Provide insured's name if a multi person app is being taken (E)

**Replacement Information**

- Answer 'yes' or 'no' to coverage being replaced question (F)
  - If an application for other coverage is pending, the replacement question should be answered 'no', unless some sort of limited, temporary coverage related to that application exists, even if no policy is to be put inforce.
  - If the replacement question is answered 'yes', then a Replacement Notice is required. However, in states that require notice form AGLC0188, the form MUST be completed if the existing coverage question (A) is answered 'yes', even if not replacing.

**1035 Information**

- Answer 'yes' or 'no' to the 1035 Exchange question. (G)

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**Existing Coverage and Replacements**

"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

**A. Do any of the Proposed Insureds have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?..... ☐ yes ☐ no** (A)

**B. If question 12A is answered "yes", please provide the following information:**

| No. | Policy Number | Year of Issue | Coverage (see below) | Benefit Period (if DI) | Type (see below) | Coverage Being Replaced? (F) | 1035 Exchange (G) |
|---|---|---|---|---|---|---|---|
| 1 | (B) | | | | | ☐Y ☐N | ☐Y ☐N |
| | Company Name: _____ (C) _____ Amount of Coverage $ _____ (D) _____ | | | | | | |
| | Proposed Insured Name: _____ (E) _____ | | | | | | |

**Notice Regarding Replacement**

- Verify use of the correct Replacement Notice for the state in which the application is signed.
- Answer all replacement and financing questions; do not leave any fields blank.
- If the existing policy or contract number is not known, applicant should write 'Unknown' in the space provided.
- Answer the **Reason for Replacement** section, if applicable.
- If the Notice has a Sales Material section, (1) complete it and (2) submit any individualized sales materials, including illustrations. If no sales materials were used, write 'None' in the space provided.
- Be sure the applicant signs and dates the form(s). **Notice Regarding Replacement must be dated on or before the date of the Part A.**
- Agent signature and date are required.

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**Reminders:**

- Group coverage being replaced does not require a Notice Regarding Replacement; however, the Existing Coverage Question and Replacement Question are all required to be completed on the Part A.
- If an existing internal cash value policy (WL, UL, VUL or ROP Term) has lapsed or was cancelled within the last 4 months, the application is processed as a replacement and all replacement requirements apply.

# Individual Life Insurance Application
## Single Insured – Part A
### Florida Version

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

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**

First Name _____ MI ___ Last Name_____ Gender ☐ M ☐ F
SSN _____ Birthplace* *(US State, or country)* _____ DOB _____ Current Age____
**Tobacco Use** Has the Primary Proposed Insured ever used any form of tobacco or nicotine products? ☐ yes ☐ no
*Type* and *Quantity* Used _____ If yes, a current user? ☐ yes ☐ no If no, date of last use _____
Driver's License ☐ yes ☐ no License State_____ Number _____
If over age of 16 and no license, please explain._____
Address _____ City _____ State _____ ZIP_____
Primary Phone_____ Alternate Phone_____ Email_____
Employer _____ Occupation _____ Date of Employment (mm/dd/yy) _____
Job Duties_____ Average No. of hours worked per week _____
Actively at work? ☐ yes ☐ no Able to perform all job duties? ☐ yes ☐ no If either is no, explain_____
Personal Earned Income (Annual): $ _____ Household Income (Annual): $_____ Net Worth $_____
Personal Earned Income means monies received for work performed.
If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force and/or pending on:
Owner $_____ Spouse $_____ Father $ _____ Mother $_____ Siblings $ _____ Premium Payor $ _____
**Citizenship** U.S. Citizen or Permanent Resident Card holder ☐ yes ☐ no If no, answer the following:
Country of Citizenship_____ Date of Entry _____ Visa Type _____ (Copy of Visa Required)
Own property or have a mortgage in the U.S.? ☐ yes ☐ no Plan to remain in the U.S.? ☐ yes ☐ no

**2. Owner - Complete if Primary Proposed Insured is not the Owner** - *(If Owner is a business, charitable entity or trust, answer question 5 below.)*

First Name _____ MI ___ Last Name_____ Gender ☐ M ☐ F
SSN _____ DOB _____ Relationship to Proposed Insured _____
Driver's License ☐ yes ☐ no License State_____ Number _____
U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship_____ Date of Entry_____
Visa Type_____ Exp. Date _____
Address _____ City _____ State _____ ZIP_____
Primary Phone_____ Email_____
*(If contingent Owner is required, use question 12.)*

**3. Reason for Insurance** - *(If Business, complete Financial Questionnaire)*_____

**4. Beneficiary** - *(If Beneficiary is a business, charitable entity or trust, answer question 5 below.)*

| No. | Name | DOB mm/dd/yy | SSN | Phone Number | Relationship | Share % | Beneficiary Type |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | ☐ Primary ☐ Contingent |
| | Address: | | Email: | | | | |
| 2 | | | | | | | ☐ Primary ☐ Contingent |
| | Address: | | Email: | | | | |
| 3 | | | | | | | ☐ Primary ☐ Contingent |
| | Address: | | Email: | | | | |

**for identification purposes only*

**5. Entity Information** - *Complete if Owner or Beneficiary is a business, charitable entity or trust. If applicable, complete the Certification of Trust.*

(Check the applicable boxes information applies to: ☐ Owner and/or ☐ Beneficiary. If also the Premium Payor, complete section 9E.)

Exact Name _____ Tax ID # _____

Address _____ City _____ State _____ ZIP _____

Current Trustee Name _____ Date of Trust _____

Corporate Officer Name _____ Title _____

Email Address of applicable Trustee or Corporate Signer _____

Relationship to Proposed Insured _____ Type of Entity (SCorp, CCorp , DBA, etc.) _____

**6. Product** - *Signed Illustration/Quotation is required for all UL & VUL products.*

Plan Name (Complete appropriate supplemental application if applicable. For Index UL, complete the Index UL Supplemental Application.)

_____

Term Duration** _____ Premium Class Quoted _____

Amount Applied For: Base Coverage $ _____ Supplemental Coverage** $ _____

Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation | Automatic Premium Loan**: ☐ yes ☐ no

**7. Death Benefit Options** - *(For UL & VUL only)* ☐ Level ☐ Increasing

**8. Riders/Benefits** - *Refer to Rider Reference Page for riders and benefits available per product.*

☐ Accidental Death Benefit $_____

☐ Child Rider[1] $_____

☐ No current children

☐ Chronic Illness Rider (AAS)[2]

☐ Lifestyle Income[3]

Withdrawal Benefit Basis %_____

☐ Terminal Illness

☐ Waiver of Monthly Deduction

☐ Waiver of Monthly Guarantee Premium

☐ Waiver of Premium

☐ Other #1 _____

Amount/Unit(s) _____

☐ Other #2 _____

Amount/Unit(s) _____

☐ Other #3 _____

Amount/Unit(s) _____

☐ Other #4 _____

Amount/Unit(s) _____

1 - Complete Child Rider Supplement
2 - Complete Chronic Illness Supplement
3 - Chronic Illness Rider (AAS) required with Lifestyle Income when AAS is approved. This requirement varies by product. Complete Chronic Illness Supplement, if applicable.

**9. Premium Payment** ☐ Modal $ _____ ☐ Single $ _____ ☐ Additional/Lump Sum $ _____

**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. Special Dating** *(not available for VUL products):* Save Age ..... ☐ yes ☐ no

**E. Premium Payor** *(Complete if Payor is other than Owner or if Owner is Trustee.)*

First Name _____ MI____ Last Name _____ Gender ☐ M ☐ F

SSN or Tax ID # _____ Relationship to Primary Proposed Insured _____

Driver's License ☐ yes ☐ no License State _____ Number _____ DOB _____

U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship _____ Date of Entry _____

Visa Type _____ Exp. Date _____

Address _____ City _____ State _____ ZIP _____

*If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form.*

**10. Existing Coverage and Replacements**

"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

**A. Does the Primary Proposed Insured have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?** ..... ☐ **yes** ☐ **no**

***Complete only if applicable*

**B. If question 10A is answered "yes", please provide the following information:**

| No. | Policy Number | Year of Issue | Coverage (see below) | Benefit Period (if DI) | Type (see below) | Coverage Being Replaced? | 1035 Exchange? |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | ☐Y ☐N | ☐Y ☐N |
| | Company Name:_____ Amount of Coverage $_____ | | | | | | |
| 2 | | | | | | ☐Y ☐N | ☐Y ☐N |
| | Company Name:_____ Amount of Coverage $_____ | | | | | | |
| 3 | | | | | | ☐Y ☐N | ☐Y ☐N |
| | Company Name:_____ Amount of Coverage $_____ | | | | | | |

**Coverage:** LI=Life, H=Health, A=Annuity, LT=LTC, DI= Disability Income **Type:** i=individual, b=business, g=group, p=pending

**11. Background Information** - *Provide details specified for all "Yes" answers or complete applicable questionnaires.*

**A.** In the past five years, has the Primary Proposed Insured flown as a pilot, student pilot or crew member of any aircraft, or have any intention to do so in the next two years? *(If yes, complete the Aviation Questionnaire)* .... ☐ yes ☐ no

**B.** In the past five years, has the Primary Proposed Insured engaged in motor sports events or racing (auto, truck, motorcycle, boat, aircraft, or other motorized vehicles); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning,) or have any intention to do so in the next two years? *(If yes, complete the Avocation Questionnaire)* ..... ☐ yes ☐ no

**C.** Has the Primary Proposed Insured ever had an application for insurance modified, rated, declined, postponed or withdrawn? *(If yes, list type of coverage, date and reason)* ..... ☐ yes ☐ no

_____

**D.** Has the Primary Proposed Insured ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? (*If filed, list chapter filed, date, reason, and discharge date)* ..... ☐ yes ☐ no

_____

**E.** In the past five years, has the Primary Proposed Insured been convicted of any driving violations to include driving under the influence of alcohol or drugs? *(If yes, list date, state, license #, and specific violation)* ..... ☐ yes ☐ no

_____

**F.** Has the Primary Proposed Insured ever been convicted of a felony or misdemeanor, or currently incarcerated or on parole or probation? (If yes, list date, county, state, charge, and current status) ..... ☐ yes ☐ no

_____

**G.** Is the Primary Proposed Insured an active duty service member of the U.S. Armed Forces? *(If yes, provide Pay Grade, Rank and any known foreign assignments, and complete any required Military Sales Disclosure)*..... ☐ yes ☐ no

_____

**H.** Within the next 2 years is there any intention that any party, other than the listed Owner or Beneficiary, will obtain any right, title, or interest in any policy issued on the life of the Primary Proposed Insured as a result of this application?..... ☐ yes ☐ no

**I.** Within the next 2 years does the Owner or Primary Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ..... ☐ yes ☐ no

**J.** Is the Owner, Primary Proposed Insured, or any person or entity, being paid (cash, services, or any other form of payment) as an incentive to enter into this transaction? *(If yes, describe the incentive)* ..... ☐ yes ☐ no

_____

**12. The space below may also be used to elaborate on answers to any questions on this application.**

_____

_____

_____

## Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured (and any Owner signing below) acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement ("LTLIA"), I understand and agree that, even if I paid a premium, no insurance will be in effect under this application or under any new policy or any rider(s) that may be issued by the Company unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of any Proposed Insured(s) that would change the answer to any question in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that, if all three conditions above are not met: (1) no insurance will be in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the conditions set forth in the LTLIA are met. I understand and agree that such temporary insurance is not available as to any riders or any accident and/or health insurance.

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 or have been read the Notices to the Proposed Insured(s).

I authorize any medical professional; any hospital, clinic or other health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; the MIB, LLC (MIB); or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability, or that of any minor child for whom application for insurance is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information concerning me, or any minor child for whom application for insurance is being made. Other information may include items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, etc.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this application. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; 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 further 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 as valid as the original. I authorize the Company, its affiliated insurers, and its affiliated service companies to obtain an investigative consumer report on me. I understand that I may: (1) request to be interviewed for the report; and (2) upon written request, receive a copy of such report.

☐ Check if you wish to be interviewed.

**Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

**TAX CERTIFICATION (Substitute Form W-9) – Applicable to U.S. persons (including U.S. citizens and resident aliens). If you are not a U.S. person, you are required to submit the applicable IRS Form W-8 series (BEN, BEN-E, ECI, EXP or IMY). Under penalties of perjury, I certify to the following:** 1. That the taxpayer identification number listed on this form is my correct SSN/TIN and I am a U.S. Citizen or other U.S. person (including resident aliens); 2. I further certify that I am exempt from and have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding. The Company is required to withhold income tax on any payments, which include interest and dividends when the owner is subject to backup withholding.; and 3. I am exempt from Foreign Account Tax Compliance Act ("FATCA") reporting. **Certification Instructions:** You must cross out any statement in 1-3 that does not apply to you. For any instructions on how to complete this certification, please see the General Instructions for the IRS Form W-9 on www.irs.gov. If you can complete a Form W-9 (Request for Taxpayer Identification Number) and you are a U.S. Citizen or U.S. resident alien, FATCA reporting may not apply to you. **Please consult your own tax advisor with any questions you may have regarding this certification.**

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

**Owner Signature**

**X** _____

**Owner Title** _____
*(If Corporate Officer or Trustee)*

**Owner signed at** (city, state) _____

**Owner signed on** (date) _____

**Primary Proposed Insured Signature** (if other than Owner)

**X** _____
*(If under age 16, signature of parent or guardian)*

**Agent(s) Signature(s)**

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* _____

State License # _____

Writing Agent Signature **X** _____

**Other Parent or Guardian Signature**

**X** _____
*(If under age 16 and coverage exceeds $150,000, signature of both parents required)*

## Agent's Report

**Policy # (if known): _____**

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** 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.

## Proposed Insured

| First Name | MI | Last Name | Date of Birth | Social Security # |
|---|---|---|---|---|
| | | | | |

**1.** Is more than one application being submitted at this time or pending for the Proposed Insured(s), family members, or business associates? *(If Yes, provide details in the Remarks section below.)* ..... ☐ yes ☐ no

**2.** Does any Proposed Insured(s) have any existing or pending annuities or life insurance policies? *(If yes, 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 - please attach such forms.)*..... ☐ yes ☐ no

**3.** If yes to question 2, do you have any information the Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for? *(If yes, please provide details in the Remarks section below and attach replacement-related forms.)*..... ☐ yes ☐ no

**4.** Are you aware of any other information that would adversely affect the eligibility, acceptability, or insurability of any Proposed Insured(s)?..... ☐ yes ☐ no

**5a.** Will a medical exam be conducted? ..... ☐ yes ☐ no

**5b.** If no, did you personally see all Proposed Insured(s) when the application was written? *(If no, provide explanation in the Remarks section below.)* ..... ☐ yes ☐ no

**6.** If accidental death is applied for, what is the total amount of accident coverage inforce and applied for?_____

**7.** Is applicant applying for an applicable QoL Advantage option available on select QoL Products? *(If yes, complete QoL Advantage Form)*..... ☐ yes ☐ no

**8.** Did you provide the Owner with a Limited Temporary Life Insurance Agreement? ..... ☐ yes ☐ no

**9.** **Remarks, Details, and Explanations** *(Please include information on any policy collateral assignments, etc.)*

_____

_____

_____

_____

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_____

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**9. Remarks, Details, and Explanations** *(continued)*

_____

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_____

**10. Agent/Agency Information** *(Please list servicing agent first)*

Note: The commission designation cannot be 100% for an agent other than the writing agent. Total allocations must equal 100%. Use whole percentages only; 0% is not a valid entry.

| Agent(s) Splitting Application | Agency Number | Local Office Code | Agent Number | Percentage of Split |
|---|---|---|---|---|
| **Servicing Agent:** _____ | _____ | _____ | _____ | _____ % |
| _____ | _____ | _____ | _____ | _____ % |
| _____ | _____ | _____ | _____ | _____ % |
| _____ | _____ | _____ | _____ | _____ % |
| _____ | _____ | _____ | _____ | _____ % |

**11. Agent Agreement and Signature**

I certify that the above information is true and complete to the best of my knowledge and belief. If I become aware of information contrary to any of the answers contained in the life insurance application to which this Agent's Report relates or contained in any supplemental applications, questionnaires, or other forms, I will notify the company of such information.

Writing Agent Name *(Please print)* _____ Date _____

Writing Agent Signature **X** _____

State License # _____ Phone # _____

Email _____ Fax # _____

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")**
**Authorization to Obtain and Disclose Information**

_____ _____/_____/_____

**Name of Insured/Proposed Insured (Please Print)** **Date of Birth**

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above) which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- MIB, LLC (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P.O. Box 9000, Amarillo, TX 79105-9000. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

**MIB ACKNOWLEDGEMENT**

I also authorize the Company, its reinsurers or authorized third party administrators to make a brief report to MIB.

**Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative**

**X**

**Signed on** (date) _____

**Signor name** (printed) _____

**Relationship** _____

**Description of Authority of Personal Representative**

(if applicable) _____

_____

**Control Number/Policy Number**_____

_____

# Bank Draft Authorization

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** 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.

**How Automatic Bank Draft Works:** Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

| Policy Number, if available | Name of Insured Applicant | Policy Number, if available | Name of Insured Applicant |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PAYMENT OPTIONS: Please select ONLY one payment option:**

☐ Draft Initial Premium and Draft Subsequent Premiums

Initial Premium: $_____.___ ☐ At Issue ☐ At Submit (Not available for all products or Employer Sponsored Plans)

- Initial premium at issue will be drafted at the time each policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.
- Initial premium will be drafted at Submit for those policies that qualify for this option. Additional initial premium due will be drafted at the time the policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.

Subsequent Premiums, if different: $_____.___

☐ Draft Only Subsequent Premiums

Check/Complete one of the following for Initial Premium payment:

☐ Check submitted with application in the amount of $_____.___.
☐ Check submitted on delivery.

**DRAFT DETAILS: Please provide the requested details.**

Preferred Withdrawal Date (1st-28th) _____ **Please debit my account for all outstanding premiums due.**

If a preferred withdrawal date is chosen and draft at issue is selected, we will draft subsequent premiums on this date.

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Type of Account: ☐ Checking ☐ Savings

Routing Number _____ (For checking account draft use routing # listed on check)

Account Number _____ (DO NOT use credit/debit card)

Bank Account Owner(s): (For business accounts, list Business and Authorized Signer Name)

Name 1 First Name (Please Print) _____ Last Name _____

Email Address 1 _____

Date of Birth 1 (MM-DD-YYYY) __/__/____ SSN1 / TIN 1 _____

Name 2 First Name (Please Print) _____ Last Name _____

Email Address 2 _____

Date of Birth 2 (MM-DD-YYYY) __/__/____ SSN1 / TIN 2 _____

Bank Account Owner's Address: (For business accounts, list Business Address)

Street _____ City _____ State _____ ZIP _____

**AGREEMENT:**

I (we) hereby authorize and request the Company or its representative to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) understand that this Authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment in its Service Center.

I (we) authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form. Any information gathered may be disclosed to any person or entity required to receive such information by law or as I may further consent.

I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request must be dated and signed by the Bank Account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

**Signature of Bank Account Owner**

**X** _____

**Date** _____

**Signature of Bank Account Owner, if joint account**

**X** _____

**Date** _____

**Please attach voided check for checking account draft or deposit slip for savings account draft.**

**LEAVE THIS FORM WITH THE PROPOSED INSURED(S)**

# NOTICES TO THE PROPOSED INSURED(S)

**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"). This notice is provided on behalf of that Company.

## 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 or health 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.

## MIB, LLC

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), which operates an information exchange on behalf of its members of MIB Group, Inc. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

## 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, if necessary, correct, amend, or delete personal information, except information that relates to a claim or a civil or criminal proceeding. This requires a written request to access your personal information and to request correction, an amendment, or deletion. We do not have to change our records if we do not agree with your request, but we will place your statement in our file. You have the right to receive a response within 30 business days of submitting a request to access, correct, amend, or delete your personal information.

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, correct, amend, or delete 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.

## USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Limited Temporary Life Insurance Agreement (Agreement)

**THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. SUCH INSURANCE IS NOT AVAILABLE FOR ANY RIDERS OR ACCIDENT AND/OR HEALTH INSURANCE. PLEASE FOLLOW STEPS 1 - 4.**

**1. Check appropriate Company:**

☐ American General Life Insurance Company, Houston, TX
☐ The United States Life Insurance Company in the City of New York, New York, NY

In this Agreement, "Company" refers to the insurance company whose name is checked above, which is responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments. In this Agreement, "Policy" refers to the Policy or Certificate applied for in the application. In this Agreement, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable.

**2. Complete the following:** *(please print)*

Primary Proposed Insured _____

Other Proposed Insured _____
*(applicable only for a joint life or survivorship policy)*

Owner *(if other than Primary Proposed Insured)* _____

Modal Premium Amount Received _____

Date of Policy Application _____

**3. Answer the following questions:**

| | Yes | No |
|---|---|---|
| a. Has any Proposed Insured ever been diagnosed with or sought treatment from a member of the medical profession for any of the following: a heart attack; stroke; coronary artery disease or other heart disease; cancer; diabetes; or disorder of the immune system, (excluding AIDS, ARC and HIV)? | ☐ | ☐ |
| b. Has any Proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? | ☐ | ☐ |
| c. Has any Proposed Insured, during the last two years: (1) been confined in a hospital or other health care facility (except for childbirth without complications); (2) received medical treatment or counseling for alcohol or drug use from a member of the medical profession or a substance abuse counselor; or (3) been advised by a member of the medical profession to have any diagnostic test or surgery not yet performed? | ☐ | ☐ |
| d. Is any Proposed Insured either less than 14 days old or over age 70 1/2? | ☐ | ☐ |

**STOP** If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.

**4. Complete and sign this section:**

Any misrepresentation contained in this Agreement and relied on by the Company may be used to deny a claim or to void this Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of this Agreement.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

*I, the Owner, have received a copy of this two-page Agreement and read it or have had it read to me and agree to be bound by the terms and conditions stated herein on the following page.*

**Owner Signature**

**X**

**Owner signed on** (date)_____

**Primary Proposed Insured (PPI) Signature** (if other than Owner)

**X**

*(If under age 16, signature of parent or Guardian)*

**PPI signed on** (date) _____

**Agent Instructions:** Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

**Other Proposed Insured (OPI) Signature** (if other than Owner)

**X**

*(If under age 16 and coverage exceeds $150,000, signature of both parents required)*

**OPI signed on** (date) _____

**Writing Agent Name** (please print) _____

**State License #** _____

## TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT

**A. Eligibility for Coverage:** If the correct answer is YES to any of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

**B. When Coverage Will Begin:**
COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

***Coverage under this Agreement will not exist until all of the conditions listed above have been met.***

The first modal premium will be considered paid, if one of the following valid items is submitted with Part A of the application and that payment is honored: (i) a check in the amount of the first modal premium; (ii) a completed and signed Bank Draft Authorization; (iii) a completed and signed Credit Card Authorization form; (iv) a completed and signed salary savings authorization; (v) a completed and signed government allotment authorization; (vi) a completed and signed payroll deduction authorization. Temporary life insurance under this Agreement will not begin if any form of payment submitted is not honored. All premium payments must be made payable to the Company checked above. Do not leave payee blank or make payable to the agent. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued, or refunded if the Company declines the application or if the policy is not accepted by the Owner.

**C. When Coverage Will End:**
COVERAGE UNDER THIS AGREEMENT WILL **END** at 12:01 A.M. ON THE **EARLIEST** OF THE FOLLOWING DATES:

- The date the policy is delivered to the Owner or his/her agent and all amendments and delivery requirements have been completed;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Company;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it has declined or cancelled the application;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that the application will not be considered on a prepaid basis;
- The date the Company mails or otherwise provides a premium refund to the Owner or his/her agent; or
- [60]calendar days from the date coverage begins under this Agreement.

**D.** The Company will pay the death benefit amount described below to the beneficiary named in the application if:

- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under this Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under this Agreement have been met.

The total death benefit amount pursuant to this Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- $1,000,000 plus the amount of any premium paid for coverage in excess of $1,000,000 ; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

**Agent Instructions:** Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

## Addendum to Application
## Policy # (if known): _____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** 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.

This addendum is part of the application to which it is attached. Addendum to *(Part A, Part B, etc.)* : _____

### Primary Proposed Insured

First Name _____ MI ____ Last Name _____ SSN _____

*(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)*

**Primary Proposed Insured (PPI) Signature**

**X**

**PPI signed on** (date) _____

**Other Proposed Insured (OPI) Signature**

**X**

**OPI signed on** (date) _____

**Owner Signature**

**X**

*(If other than Primary Proposed Insured)*

**Owner signed on** (date) _____

# HIV Testing and Consent
## Florida Version

**American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
**The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

**Notice and Consent for Bodily Fluids Testing Which May Include AIDS Virus (Antibody) Testing**

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your bodily fluids (blood, urine, and/or oral fluid) for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

**Pre-Testing Considerations**

Many public health organizations have recommended that before taking an AIDS-related bodily fluids test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

**Meaning of Positive Test Results**

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

**Positive HIV antibody test results will adversely affect your application for insurance.**

**Confidentiality of Test Results**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

**Notification of Test Results**

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health and Rehabilitation. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result:_____

Address:_____

**Consent**

I have read and I understand this Notice and Consent for AIDS-Related Bodily Fluid Testing. I voluntarily consent to the withdrawal of blood from me and/or collection of other bodily fluids, the testing of bodily fluids, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

**Signature of Proposed Insured or Parent/Guardian**

**X**

**Date signed** _____

**Name of Proposed Insured** (printed) _____

_____

**Address of Proposed Insured** _____

_____

Submit this form with the application

# Secondary Addressee Designation
## Florida Version

**American General Life Insurance Company**
**The United States Life Insurance Company in the City of New York**
**Service Center:** P.O. Box 818005, Cleveland, OH 44181

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You have the right to designate one person, in addition to the applicant or policyowner, to receive notice of lapse or cancellation of a policy for nonpayment of premium. What does this mean? It means that a copy of the notice of lapse or cancellation that is sent to the policyowner will also automatically be sent to a second person, selected by you, who can assist you in making timely payments in order to prevent a lapse in coverage.

You are under no obligation to designate a secondary addressee, however if you would like to do so, please complete the information below and submit it with your application for life insurance or at such time as you may choose to designate a secondary addressee. **Customer Instruction:** If this designation form is for an existing policy that you own, please send the form to the following address: PO Box 818005 • Cleveland, OH 44181.

The policyowner may change the designation at any time the policy is in force by submitting a written notice to the Company containing the name and address of the secondary addressee.

Note: Your designation on this form will replace and revoke any prior designations of secondary addressees previously made by you.

***Secondary Addressee:***

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____

**Applicant/Policyowner's Signature**

**X** _____

**Applicant/Policyowner signed on** (date) _____

**Applicant/Policyowner's name** (printed) _____

_____

**Policy Number(s), if known:** _____

# Notice to Applicant Regarding Replacement of Life Insurance
## Florida Version

**American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019

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A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer by placing **your initials in the appropriate box below**.

| | |
|---|---|
| | |
| Yes | No |

**DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.**

I have read this notice and received a copy of it.

**Applicant's Signature**

X

**Applicant signed on** (date) _____

**Applicant's name** (printed) _____

_____

**Agent's Signature**

X _____

**Agent signed on** (date) _____

**Agent's name** (printed or typed) _____

_____

**Agent's company** (printed or typed) _____

_____

**Agent's address** (printed or typed) _____

_____

Information on policies which may be replaced:

| Company Name | Policy Number | Name of Insured |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

ORIGINAL–HOME OFFICE COPY–PROPOSED INSURED

# Comparative Information Form for Proposed Insured

**(Please return one copy of this form to the Home Office with the application)**

**American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019

(Replacing Agent's Name) _____

## APPLICANT INFORMATION

Name _____
Address _____
_____
Telephone _____
Date of Birth _____ Age _____

## POLICY INFORMATION

Policy Generic Name _____
Policy Number _____
Date of Issue _____ Issue Age _____
Contestable Period Expires _____
Suicide Period Expires _____
Policy Loan Rate _____

## POLICY/RIDER DESCRIPTION

| POLICY/RIDER NAME | INITIAL CONTINUING BENEFIT | BENEFIT (Age) | | INITIAL/RENEWAL ANNUAL PREMIUM | PAYABLE (Age) | |
|---|---|---|---|---|---|---|
| | | FROM | TO | | FROM | TO |
| | | | | | | |

TOTAL INITIAL ANNUAL PREMIUM $_____ MODE OF PYMT. _____ AMOUNT $_____
TOTAL RENEWAL ANNUAL PREMIUM $ _____ AMOUNT $_____

## COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

| | | GUARANTEES | | | | PROJECTIONS* | | | |
|---|---|---|---|---|---|---|---|---|---|
| YR. | AGE | ANNUAL PREMIUM | CUMULTV. PREMIUM | CASH VALUE | DEATH BENEFIT | ANNUAL PREMIUM | CUMULTV PREMIUM | CASH VALUE | DEATH BENEFIT |
| 1 | | | | | | | | | |
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| | 60 | | | | | | | | |
| | 65 | | | | | | | | |
| | 75 | | | | | | | | |
| | 85 | | | | | | | | |
| | 95 | | | | | | | | |

* Projections include dividends and current interest rates which are not guaranteed.
IMPORTANT NOTICE: The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implications.

**INSTRUCTIONAL NOTES FOR COMPLETION OF COMPARATIVE INFORMATION FORM**

1. In the disclosure of values, premiums shall be shown only if they increase the cash value or death benefits for the primary insured.

2. Any benefits for secondary insureds shall be shown on a supplementary exhibit.

3. Values will be shown for each year in which either an initial change in face value or premium payment occurs.

4. Values will be shown in the disclosure for the maximum duration policy guarantees permit. If this benefit extension requires that guaranteed policy options be utilized, the option to be used will be that (those) automatically utilized by the issuing insurer. However, if the policy application provides for applicant election of an alternative option which is binding on the insurer and the applicant elects to make an alternative election, then the extension of benefits will employ the option actually elected by the applicant. Any option utilized for extension of benefits must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form.

5. The dividend option elected by an insured or applicant must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form. The dividend option elected by the insured or applicant must be employed in completing the composite disclosure of values.



# Agent Certification Form

☐ **American General Life Insurance Company**
☐ **The United States Life Insurance Company in the City of New York**

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** 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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Insured's Social Security Number _____ Policy Number _____

Additional Insured's Social Security Number_____

This form must be completed prior to taking any application for life insurance on an individual age 67 or older. The Company may also request agents to complete this Form in other situations where it is deemed appropriate.

Carefully review this Form and Company Field Bulletins regarding Investor Owned Life Insurance and Stranger Owned Life Insurance, and complete the certification below that applies to the transaction; except, however, if part or all of the premium paid toward this policy is being financed and you cannot sign the certification, you must not take the application.

**Non-Premium Financing Certification**

None of the premiums for the policy sought with the application for (Insured) _____ or for _____(Additional Insured) dated_____will be financed other than pursuant to a split dollar agreement, including a family's private split dollar agreement.

**Agent's Signature X** _____ **Agent signed on** (date) _____

**Premium Financing Certification**

1) I have reviewed and am familiar with all aspects of the premium financing proposal.
2) Based upon my review of the financing proposal, I believe that the costs associated with this premium financing proposal are such that assuming no change in the insured/additional insured's health, it is more likely than not that the insured/additional insured will maintain the policy in force for the benefit of his/her beneficiaries and those beneficiaries will receive more than 50% of the policy death benefit.
3) The insured/additional insured is not receiving any cash payment, borrowing funds in excess of those required to pay the scheduled premiums and interest, or receiving any other consideration as an inducement to participate in this transaction.
4) Within the past 24 months has the insured/additional insured had a life expectancy calculation? ☐ Yes ☐ No
   All life expectancy calculations performed on any proposed insured during the past 24 months must be submitted with any application for review and consideration.
5) There is no prearranged agreement to transfer the policy nor will the policyholder have a prearranged option or right of first refusal to transfer the policy to a third party.
6) All sales materials used in connection with the solicitation and sale of this policy were either produced by the life insurance company or have been submitted and approved by the Company.
7) I have read the Field Bulletins regarding Investor Owned Life Insurance, Stranger Owned Life Insurance and Viatical Transactions, and believe this transaction is in compliance with the company policies as set forth in those Bulletins regardless of whether the lending program is a recourse or non-recourse transaction.

All or part of the premiums paid towards this policy are being financed. I have read the statements set forth above and hereby certify that the statements are all true with regard to the application for (Insured) _____ _____ and _____ (Additional Insured) dated _____ .

**Agent's Signature X** _____ **Agent signed on** (date) _____

# Premium Financing Disclosure for Proposed Insureds

**American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019

In this form, the "Company" refers to the insurance company name listed above. The Company shown above is **solely** 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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We are providing this notice to all insureds age 67 or older who have applied for life insurance policies, as we have seen unprecedented growth in premium financing for policies in this demographic.

Premium financing is a practice that has been used in connection with the sale of life insurance policies for many years. If you are contemplating financing the purchase of life insurance or participating in the acquisition of a life insurance policy acquired with funds from a source outside your control, please consider the following issues:

- All the questions on the life insurance application should have been answered accurately and completely. Misrepresentations about your health, your financial resources or the purpose for acquiring the policy may result in claims disputes rather than payment of insurance benefits.

- Be sure you understand the transaction. Some transactions are established with a trustee or other third party who obtains financing from a lender on terms that may not be to the insured's advantage. Ask yourself, are the parties involved looking out for your best interest?

- Will a significant portion of your policy death benefit reach your beneficiaries? If most of the death benefits are not going to your beneficiaries, perhaps you should consider acquiring a more affordable policy that you control for your beneficiaries.

IMPORTANT: Any payments received as an inducement for entering into a life insurance transaction are taxable as ordinary income. Also, if you have financed premiums to pay for a policy with the understanding that you can walk away after the initial term with no personal obligation to repay the loan or loan interest, it is possible that forgiveness of debt can also create taxable income for you. If you sell your policy the gain is taxable to you. You should consult with your personal tax advisor about any questions you may have regarding the tax consequences of this transaction.

- It is important to know the lender, the trustee or other parties participating in the transaction. Ask whether you are comfortable participating in a transaction where investors or entities you do not know may end up owning a large insurance policy on your life.

This is not a complete list of all the issues that you should consider when contemplating a new life insurance transaction. If you have any questions or concerns, you can contact your Agent or call our Company at 1-800-247-8837, prompt 1.

Please acknowledge that you have received this disclosure by signing a copy of this form and returning it to the Company. Retain a copy for your records.

**Proposed Insured's Signature**

**X** _____

**Proposed Insured signed on** (date) _____