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

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)

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.

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

☐ **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 %	Beneficiar 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 Nam _____ 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. Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? *(If yes, list country(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire)*. . . . . ☐yes ☐no

_____

B. 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

C. In the past five years, has the Primary Proposed Insured engaged in motor sports events or racing (auto, truck, motorcycle, boat, etc.); 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

D. 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

_____

E. 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

_____

F. In the past five years, has the Primary Proposed Insured pled guilty or 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

_____

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

_____

H. 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

_____

I. Is there an 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

J. 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

K. 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, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, 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.

IRS Certification: Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: _____), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person*, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: _____). **Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you can complete a Form W-9 and you are a U.S. citizen or U.S. resident alien, FATCA reporting may not apply to you. Please consult your own tax advisors.

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)*_____

Writing Agent # _____

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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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, including but not limited to Acquired Immune Deficiency Syndrome (AIDS) or infection by the Human Immunodeficiency Virus (HIV)?	☐	☐
b. 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; or (3) been advised to have any diagnostic test or surgery not yet performed (except for those tests related to the Human Immunodeficiency Virus (HIV))?	☐	☐
c. 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.

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) _____

Writing Agent # _____

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
Georgia 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 FDA Approved Bodily Fluids Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

EXAMINER _____

_____

To determine 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. All tests are FDA approved and will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. If the Insurer is a member of MIB, LLC (MIB) and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to MIB, a generic code which signifies only a nonspecific bodily fluid test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to MIB. Other test results may be reported to MIB, in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant bodily fluid abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent for FDA Approved Bodily Fluids Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle 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 this consent shall be valid for thirty (30) months following the date shown below.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request, to an insurance institution (insurers), agent, or insurance support organization for access to recorded personal information and a copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent, or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information; and the reasons why I disagree with such refusal to correct, amend, or delete recorded personal information.

Signature of Proposed Insured or Parent/Guardian

X

Date signed _____

Proposed Insured's name (printed) _____

_____

Date of Birth _____

State of Residence _____

Submit this form with the application

LIFE INSURANCE BUYER'S GUIDE

This guide can show you how to save money when you shop for life insurance. It helps you to:

Decide how much life insurance you should buy;
Decide what kind of life insurance policy you need; and
Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by American General Life Insurance Company

May 2015

AGLC108755-01

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this guide in making a life insurance purchase.

THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.

Buying Life Insurance

When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay, and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses for final illnesses, paying taxes, mortgages, or other debts. It can also provide income for your family's living expenses, educational costs, and other future expenses.

Your new policy should come as close as you can afford to make up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds or life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance.

The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection for a "term" for one or more years, Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period, such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance

An endowment insurance policy pays a sum or income to you — the policyholder — if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than for the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low-Cost Policy

After you have decided which kind a life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index," and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them ONLY for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What Is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "nonparticipating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash Values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply, and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

1. LIFE INSURANCE SURRENDER COST INDEX. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
2. LIFE INSURANCE NET PAYMENT COST INDEX. This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs or similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a nonparticipating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the nonparticipating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

1. Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

2. Compare index numbers only for the kind of policy, for your age, and for the amount you intend to buy. Since no one company offers the lowest cost for *all* types of insurance at *all* ages and for *all* amounts of insurance, it is important that you get the indexes for all actual policy, age, and amount which you intend to buy. Just because a "Shopper's Guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

3. Small differences in index numbers could be offset by other policy features or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

4. In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums and that you understand its cash values, dividends, and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future to you as a policyholder.

5. These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

Important Things to Remember — A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you can make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.