



- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- AIG Life Insurance Company, Wilmington, DE

Member companies of American International Group, Inc.

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

1. Primary Proposed Insured

Name _____ Social Security # _____

Sex M F Birthplace* (state, country) _____ Date of Birth _____ Current Age _____

Tobacco Use Have you ever used any form of tobacco or nicotine products? yes no If yes, date of last use _____

If yes, type and quantity of tobacco or nicotine products used _____

Driver's License yes no Number _____ License State _____

U.S. Citizen yes no If no, Date of Entry _____ Visa Type _____ Exp. Date _____

Address _____ City, State _____ ZIP _____

Home Phone () _____ Work Phone () _____ Email _____

Employer _____ Occupation _____ Length of Employment _____

Employer Address _____ City, State _____ ZIP _____

Duties _____

Personal Earned Income \$ _____ Household Income \$ _____ Net Worth \$ _____

If Primary Proposed Insured is a child or is age 18 or over and not self-supporting, what amount of insurance is in force on any of the following: Spouse \$ _____ Father \$ _____ Mother \$ _____ Siblings \$ _____

2. Owner

A. Complete if the Primary Proposed Insured is not the Owner (If contingent Owner is required, use Remarks section.)

Name _____ Social Security or Tax ID # _____ Date of Birth _____

Address _____ City, State _____ ZIP _____

Home Phone () _____ Relationship to Primary Proposed Insured _____

Email _____

B. Complete if Owner is a trust (If trustee is premium payor also complete section 8 D.)

Exact Name of Trust _____ Trust Tax ID # _____

Address _____ City, State _____ ZIP _____

Email _____

Current Trustee(s) _____ Date of Trust _____

3. Plan of Insurance

Product Name _____ Amount Applied For \$ _____

Premium Class Quoted _____ Reason for Insurance _____

Riders/Benefits

Child Rider Amount \$ _____ (Complete Child Rider Attachment) or No current children

Waiver of Premium Accidental Death Benefit Amount \$ _____

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

Number of Units (1 unit = \$100): _____ Occupational Class (Please check): 1 2

Other Riders/Benefits #1 _____ Amount/Unit(s) _____

Other Riders/Benefits #2 _____ Amount/Unit(s) _____

*for identification purposes only

4. **Primary Beneficiary** Name _____ Relationship _____ Share _____%
 Name _____ Relationship _____ Share _____%
 Name _____ Relationship _____ Share _____%

5. **Contingent Beneficiary** Name _____ Relationship _____ Share _____%
 Name _____ Relationship _____ Share _____%
 Name _____ Relationship _____ Share _____%

6. **Trust Information (if Beneficiary)** Exact Name of Trust _____
 Trust Tax ID # _____ Current Trustee(s) _____ Date of Trust _____

7. **Business Insurance Details** (Complete only if applying for business coverage.)
 Does the Primary Proposed Insured have an ownership interest in the business? yes no
 If yes, what is the percentage of ownership for the Primary Proposed Insured? _____%
 Net Profit of Business \$ _____ Fair Market Value of Business \$ _____
 If buy-sell, stock redemption, or key person insurance, will all partners or key people be covered? yes no
 Describe any special circumstances. _____

8. **Premium Payment** Modal \$ _____
A. Frequency of modal premium: Annual Semi-annual Quarterly Monthly (Bank Draft only)
B. Method: Direct Billing Bank Draft (Complete Bank Draft Authorization.) List Bill: Number _____
 Credit Card - Initial Premium Only (Complete Credit Card Authorization.)
 Other (Please explain.) _____
C. Amount submitted with application \$ _____
D. Premium Payor (Complete if other than Owner.) Relationship to Primary Proposed Insured _____
 Name _____
 Social Security or Tax ID # _____
 Address _____ City, State _____ ZIP _____

9. **Health and Age Questions** (Regarding the Primary Proposed Insured, if the correct answer to either question below is "yes" or any question is answered falsely or left blank, coverage is not available under the Limited Temporary Life Insurance Agreement ("LTLIA") and it is void, and any payment submitted will be refunded. Read the LTLIA for additional terms and conditions of coverage.)
A. Has the Primary Proposed Insured ever had a heart attack, stroke, cancer, diabetes, or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? yes no
B. Is the Primary Proposed Insured age 71 or above? yes no

10. Existing Coverage

A. Life and Annuity Coverage

Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies? yes no

(If yes, complete the following regarding such annuities or life insurance policies.)

Type: **i** = individual, **b**= business, **g**=group, **p**=pending life insurance or annuity

Policy Number	Insurance Company	Type(s) (see above)	Year of Issue	Face Amount	Replace*
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

***Replace** means that the insurance being applied for may replace, change or use any monetary value of any existing or pending life insurance policy or annuity. If replacement may be involved, complete and submit replacement-related forms. Please note: certain states require completion of replacement related forms even when other life insurance or annuities are not being replaced by the policy being applied for.

10. Existing Coverage (continued)

B. Disability Coverage (Complete only if Disability Income Rider coverage requested.)

Does the Primary Proposed Insured have any existing or pending Disability insurance policies? yes no

(If yes, complete the following regarding existing or pending disability insurance)

Insurance Company	Benefit Amount	Benefit Period	Elimination Period	Year Issued

11. Background Information (Complete questions A through F. If yes answer applies to the Primary Proposed Insured, provide details specified after each question.)

A. Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? yes no

(If yes, list country, date, length of stay and purpose.) _____

B. In the past five years, has the Primary Proposed Insured participated in, or does he or she intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; extreme sports or other hazardous activities? yes no

(If yes, circle or list the applicable activities and complete the Aviation and/or Avocation Questionnaire.) _____

C. Has the Primary Proposed Insured:

1) During the past 90 days submitted an application for life insurance to any company or begun the process of filling out an application? yes no

(If yes, list company name, amount applied for, purpose of insurance and if application will be placed.) _____

2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal? yes no

(If yes, list date and reason.) _____

D. Has the Primary Proposed Insured ever filed for bankruptcy? yes no

(If yes, list chapter filed, date, reason and discharge date.) _____

E. In the past five years, has the Primary Proposed Insured been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? yes no

(If yes, list date, state, license no. and specific violation.) _____

F. Has the Primary Proposed Insured ever been convicted of or pled guilty or no contest to a criminal offense or currently have any felony or misdemeanor charge pending? yes no

(If yes, list date, state and charge.) _____

REMARKS

12. Details and Explanations _____

The above listed life insurance company ("Company") as selected on page one of this application 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.

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured and Owner signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. 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, 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) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of the Proposed Insured(s) that would change the answers to any questions 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 begin 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.

Limited Temporary Life Insurance Agreement ("LTLIA") – 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 only if the following four conditions are met: (1) the full first modal premium is submitted with this application and paid; and (2) only "no" answers have been truthfully given to the Health and Age Questions in section 9; and (3) Part A and Part B of the application must be completed, signed and dated; and (4) all medical exam requirements must be satisfied. I understand and agree that such insurance is not available with 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 or have been read the Notices to the Proposed Insured(s).

I give my consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an affiliated service company), and 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 for me, my spouse or my minor children. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine: (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may 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 AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. Check if you wish to be interviewed.

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; and (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

Primary Proposed Insured/Owner Signature

Signed at (city, state) _____ On (date) _____

Primary Proposed Insured _____
(If under age 15, signature of parent or guardian)

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

Agent Signature

I certify that the information supplied by the Primary Proposed Insured and Owner has been truthfully and accurately recorded on the Part A application.

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

Writing Agent Signature _____ Countersigned _____
(Licensed resident agent if state required)

Agent's Report

1. Statements

- A.** Number of years you have known the Primary Proposed Insured: _____
- B.** Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies? yes no
If yes, do you have any information that indicates that the Primary Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity with any company in connection with the purchase of insurance? yes no
(If yes, please provide details in the Remarks section below and attach all replacement-related forms. 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.)
- C.** Are you aware of any other information that would adversely affect the Primary Proposed Insured's eligibility, acceptability, or insurability? *(If yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.)* yes no
- D.** Did you provide the Owner with a Limited Temporary Life Insurance Agreement? yes no

2. Remarks, Details and Explanations *(Please include information on any collateral assignment, etc.)*

3. Commission, Agent/Agency Information *(Please list servicing agent first.)*

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
_____	4HH82	_____	%
_____	_____	_____	%
_____	_____	_____	%
_____	_____	_____	%

Writing Agent Name *(Please print)* _____ Date _____
Writing Agent Signature **X** _____
State License # _____ Phone # _____
Email _____ Fax # _____

For Home Office use

Processing Center _____ Contact Person _____ Phone # _____
Servicing Agent (if other than writing agent) send policy/delivery requirements to _____

Detach this page and leave it with the Proposed Insured(s)
NOTICES TO THE PROPOSED INSURED(S)

**X American General Life
Insurance Company,
Houston, TX**

**The United States Life Insurance Company
in the City of New York,
New York, NY**

**AIG Life Insurance
Company,
Wilmington, DE**

The life insurance company checked on page 1 of your application ("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. This notice is provided on behalf of the Company and American General Life Companies LLC, an affiliated service company.

FAIR CREDIT REPORTING ACT AND INVESTIGATIVE CONSUMER REPORTING AGENCIES ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), and your state's Investigative Consumer Reporting Agencies Act, notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that could include information about your character, general reputation, personal characteristics and mode of living, from one of the following consumer reporting agencies:

Systematic Business Services, Inc.,
10101 Renner Boulevard,
Lenexa, KS 66219-9752, 800-444-7274

Portamedic,
170 Mt. Airy Rd.,
Basking Ridge, NJ 07920, 800-444-3737

Examination Management Services, Inc.,
3003 LBJ Freeway, Suite 200,
Dallas, TX 75234, 800-USA-EMSI

If an investigative consumer report is ordered a copy will be provided to you within three (3) days after our receipt of the report.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. 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 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 (TTY 866-346-3642). 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 Post Office Box 105, Essex Station Boston, Massachusetts 02112.

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.

INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: American General Life Companies LLC, 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.

This form must be completed, signed and **left with the applicant.**

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
- AIG Life Insurance Company, Wilmington, DE

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 had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed?	<input type="checkbox"/>	<input type="checkbox"/>
b. Is any Proposed Insured age 71 or above?	<input type="checkbox"/>	<input type="checkbox"/>

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.

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 Automatic Bank Draft Agreement; (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
- \$500,000 plus the amount of any premium paid for coverage in excess of \$500,000; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

4. Complete and sign this section:

Any misrepresentation contained in this Agreement or the Receipt 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 or the Receipt.

I, the Owner, have received and read this Agreement and the Receipt or they were read to me and agree to be bound by the terms and conditions stated herein.

Signature of Owner _____ Date _____

Signature of Primary Proposed Insured _____ Date _____

Signature of Other Proposed Insured (if applicable) _____ Date _____

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

This form to be completed, detached and **submitted with the signed application.**

Limited Temporary Life Insurance Agreement Receipt

1. Check appropriate Company:

- Checkboxes for American General Life Insurance Company, The United States Life Insurance Company, and AIG Life Insurance Company.

In this Receipt, "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. The "Agreement" refers to the Limited Temporary Life Insurance Agreement.

2. Complete the following: (please print)

Primary Proposed Insured
Other Proposed Insured
Owner (if other than Primary Proposed Insured)
Modal Premium Amount Received

3. Answer the following questions:

Table with 3 columns: Question, Yes, No. Contains two questions about health conditions and age.

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 the Agreement and it is void.

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 the Agreement was in effect, except due to suicide; and
All eligibility requirements and conditions for coverage under the Agreement have been met.

The total death benefit amount pursuant to the 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
\$500,000 plus the amount of any premium paid for coverage in excess of \$500,000.

If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

4. Complete and sign this section:

Any misrepresentation contained in the Agreement or this Receipt and relied on by the Company may be used to deny a claim or to void the Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of the Agreement or this Receipt.
I, the Owner, have received and read the Agreement and this Receipt or they were read to me and agree to be bound by the terms and conditions stated therein.
Signature of Owner
Signature of Primary Proposed Insured
Signature of Other Proposed Insured (if applicable)
Writing Agent Name (please print) Writing Agent #



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

Members of American International Group, Inc.

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

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

Notice and Consent for AIDS Virus (HIV) Antibody Testing

To determine your insurability, the Company has requested that you provide a sample or samples of your bodily fluids (blood, urine, and/or oral fluid) as may be allowed under state or jurisdictional law for testing and analysis. One of the tests to be performed will determine the presence or absence of antibodies to the Human Immunodeficiency Virus (HIV). The testing will be performed by a licensed laboratory in accordance with guidelines approved by the Centers for Disease Control. By signing and dating this form, you agree that this testing may be done and that underwriting decisions may be based upon the test results.

Information on HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing. Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

Pre-Testing Considerations

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

Meaning of Test Results

A positive result, which is a series of three positive tests, does not mean you have Acquired Immune Deficiency Syndrome (AIDS). A positive test indicates that you have been infected with HIV, the causative agent for AIDS, and that you are at significantly increased risk of developing alterations of your immune system, including AIDS and AIDS-Related Complex (ARC). The test for HIV antibodies is extremely accurate and reliable. However, in rare instances, the test may be positive in individuals who are not infected with the virus (false positive) and occasionally it may be negative in persons infected with HIV (false negative), especially when infection occurred within the 3-6 months prior to testing. Your private physician, a public health clinic or an AIDS information organization in your city can provide you with further information on the medical implications of a positive test.

Disclosure of Test Results

All test results will be treated confidentially. The laboratory will report them only to the Company. The test results may be disclosed as required by law or may be disclosed to employees of the Company who have responsibility for making underwriting decisions on behalf of the Company or to outside legal counsel who needs such information to effectively represent the Company in regard to your application. The results may be disclosed to a reinsurer if the reinsurer is involved in the underwriting process. Please also be advised that the jurisdiction in which you reside may require reporting of positive HIV test results or other test results by the Company and/or the laboratory that conducts the test to a regulatory agency. Such reporting may include disclosure of personal information such as your name, address and date of birth.

If your HIV antibody test is normal (negative), no routine notification will be sent. You will be notified of an abnormal (positive or indeterminate) test result if you indicate that you desire this result be made known to you. You may also identify another person to whom you want the abnormal results released. If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

If your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB) as described in the notice given you at the time of application. The MIB is an organization of life and health insurance companies, which operates as an information exchange on behalf of its members. There will be no records with the MIB that you had a positive HIV antibody test; however, there will be a record that you have some laboratory abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request and with your authorization, will supply the information on you in its file to that member.

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

_____/_____/_____
Name of Patient/Proposed Insured (Please Print)

Date of Birth

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, AIG Life Insurance Company of Puerto Rico, American General Life Insurance Company, American Home Assurance Company, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service company), (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; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company 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
- the Medical Information Bureau (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 under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect health care 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 insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG American General 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: AIG American General Service Center, P.O. Box 4373, Houston, TX 77210-4373. 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 medical 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.

Signature of Proposed Insured or
Proposed Insured's Personal Representative

Date

Description of Authority of Personal Representative
(if applicable)



American General Life Insurance Company

Member of American International Group, Inc.

P.O. Box 2764 • Houston, TX 77252 • 713-522-1111

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way, you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.



X _____
APPLICANT'S SIGNATURE



X _____
AGENT'S SIGNATURE

DATE



Insured's Name	Company	Contract Number