

**American General Life Insurance Company of Delaware\***

Wilmington, Delaware

Administrative Office P.O. Box 30083, Tampa, FL 33630-3083

\*This company does not solicit business in New York.

Application is hereby made for a plan of Critical Illness insurance based on the following statements and representations:

**1. Identification of Policyholder:**

**Policy Number:** \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Address of Policyholder: \_\_\_\_\_  
City State Zip

Contact Name and Title \_\_\_\_\_ E-Mail: \_\_\_\_\_

Type of Organization: \_\_\_\_\_ Nature of Business: \_\_\_\_\_

SIC Code \_\_\_\_\_ Number of Eligible Persons: \_\_\_\_\_

Name(s) of Affiliates(s) or Subsidiary(ies) to be covered: \_\_\_\_\_

**2. Classification of Eligible Persons:**

**3. Policy Coverage:**

Please include the sold proposal output material.

Group CriticalCare:  Plan A  Plan B  Plan C  Other

Group CancerCare Lump Sum Amount:  \$1,250  \$2,500  \$5,000  Other

**4. Premiums:**

The Policyholder agrees to pay the required premium for these coverages.

**5. Policy Effective Date:** \_\_\_\_\_

**6. Contribution Information:**

Will Eligible Persons contribute to the cost of insurance?  Yes  No

If Yes, please provide percentage of each coverage that the Policyholder will pay. \_\_\_\_\_ %

**7. Replacement Coverage:**

Will this Group Policy replace a Policy providing similar benefits?  Yes  No

\_\_\_\_\_  
Signed for the Policyholder

\_\_\_\_\_  
Title

**8. Producing Agent Declaration**

Producer #: \_\_\_\_\_ Tax ID: \_\_\_\_\_ % of commission to split with other agent: \_\_\_\_\_

Name as licensed: \_\_\_\_\_ License Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

City and state where signed: \_\_\_\_\_