

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, in advance, 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: _____